C+D

Chemist+Druggist
news+education+tools for the pharmacy community
www.chemistanddruggist.co.uk
28 June 2008

C+D Awards: see the pictures

page 26

THE POWER TO

CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK. (See Champix Summary of Product characteristics for full Prescribing Information). Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with *"Pfizer"* on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with *"Pfizer"* on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment:* No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events:* Dosing may be reduced to 1 mg once daily. *Severe renal impairment:* 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease:* Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** *Effect of smoking cessation:* Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). Depressed mood may be a symptom of nicotine withdrawal. Depression, rarely including suicidal ideation and suicide attempt, has been reported in patients undergoing a smoking cessation attempt. These symptoms have also been reported while attempting to quit smoking with Champix. Clinicians should be aware of the possible emergence of significant depressive symptomatology in patients undergoing a smoking cessation attempt, and should advise patients accordingly. There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the

HELP THEM QUIT.[1-4]

NOW WITH DIRECT NRT COMPARISON

- *CHAMPIX* at 12 weeks provides significantly greater quit success vs. NRT (NiQuitin CQ Clear®)[5]
- 1.7x greater odds of quitting smoking after *CHAMPIX* at 12 weeks vs. NRT patch (odds ratio = 1.70; p<0.001)[5*]
- *CHAMPIX* also enables significantly more smokers to quit at 12 weeks than those who used bupropion or placebo[1,2]

CHAMPIX®
varenicline tartrate

*The recommended treatment course for *CHAMPIX* is 12 weeks and for the NRT patch (NiQuitin CQ Clear®) is 10 weeks. Continuous abstinence rate was CO-confirmed at weeks 9-12 for *CHAMPIX* and at weeks 8-11 for NRT.

enefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or oderate influence on the ability to drive and use machines. Champix may cause dizziness nd somnolence and therefore may influence the ability to drive and use machines. atients are advised not to drive, operate complex machinery or engage in other otentially hazardous activities until it is known whether this medicinal product affects eir ability to perform these activities. **Side-Effects:** Adverse reactions during clinical als were usually mild to moderate. Most commonly reported side-effects were abnormal reams, insomnia, headache and nausea. Commonly reported side-effects were increased ppetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal stension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC r less commonly reported side-effects. **Overdose:** Standard supportive measures ba adopted as required. Varenicline has been shown to be dialyzed in patients with nd stage renal disease, however, there is no experience in dialysis following overdose. **gal category:** POM. **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1mg tablets Card U/1/06/360/003) £27.30, Pack of 28 1mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1mg tablets HDPE Bottle U/1/06/360/002) £54.60, Pack of 56 1mg tablets Card (EU/1/06/360/005) £54.60. Not all ck sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer mited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer mited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 02/2008

Adverse events should be reported to Pfizer Medical Information on 01304 616161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

For further information, please contact Pfizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

References: 1. Gonzales D *et al.* Varenicline, an α4β2 nicotinic acetylcholine receptor partial agonist, vs sustained-release bupropion and placebo for smoking cessation: A randomized controlled trial. JAMA 2006; 296:47-55. 2. Jorenby DE *et al.* Efficacy of varenicline, an α4β2 nicotinic acetylcholine receptor partial agonist, vs placebo or sustained-release bupropion for smoking cessation: A randomized controlled trial. JAMA 2006; 296:56-63. 3. Tonstad S *et al.* Effect of maintenance therapy with varenicline on smoking cessation: A randomized controlled trial. JAMA 2006; 296:64-71. 4. Gonzales DH *et al.* A pooled analysis of varenicline, an alpha 4 beta 2 nicotinic receptor partial agonist vs. bupropion, and placebo, for smoking cessation. Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2 5. Aubin H-J *et al.* Varenicline versus transdermal nicotine patch for smoking cessation: Results from a randomised, open-label trial. Thorax Published Online First: 8 February 2008. doi:10.1136/thx.2007.090647.

Pfizer

Date of preparation: February 2008. CHA432b

"In my 24 years' experience as a cosmetic scientist, I've rarely come across a more impressive skincare product than Bio-Oil."

John Knowlton
Past President of The Society of Cosmetic Chemists of Great Britain

Bio-Oil® is clinically assessed to help improve the appearance of scars and striae. It contains natural plant oils, vitamins and the breakthrough ingredient PurCellin Oil™. Bio-Oil should be applied twice daily for a minimum of 3 months. It is available at pharmacies and selected retail outlets from £8.95. bio-oil.com

THE UK'S NO.1 SELLING SCAR PRODUCT*

Results of clinical trials: Medical University of South Africa, Photobiology Laboratory. 1) Scars: improvement in appearance in 65% of the scars at 4 weeks. 2) Striae: improvement in appearance in 50% of the striae at 8 weeks. Protocol: controlled conditions, intra-subject comparison, clinician assessed (blinded).
*IRI Infoscan 52 w/e Nov 2007

Editor
Gary Paragpuri MRPharmS
01732 377688
Features & Deputy Editor
Fiona Salvage MRSC
01732 377435
News Editor
Max Gosney
01732 377315
Marketing Editor
Lesley Ribbens
01732 377600
Online Editor
Tom Hawkins
01732 377284
Clinical & CPD Editor
Gavin Atkin
01732 377239
Contributing Editor
Adrienne de Mont FRPharmS
Reporters
Jennifer Richardson
01732 377088
Zoe Smeaton
01732 377441
Group Production Editor
Fay Jones
01732 377396
Deputy Group Production Editor
Harriet Kinloch
01732 377112
Group Art Editor
Richard Coombs
01732 377528
Designers
David Farram 01732 377113
Jo Konopelko 01732 377231
Office Manager
Elaine Steele 01732 377621
(fax): 01732 367065
esteele@cmpmedica.com
Marketing Manager
Emily Miles
01732 377612
Sales Director
Ruth McKay
020 7921 8456
Advertisement Managers
Daniel Spruytenburg
020 7921 8126
Deborah Heard
020 7921 8119
Sales Executive
Chris Docwra 020 7921 8123
Classified Sales Executive
Simon Pittman 020 7921 8333
Price List
Colin Simpson (Controller)
01732 377407
Darren Larkin (Data Manager)
Price List (fax): 01732 377559
Sandra Drawbridge (Data Input Clerk)
C+D Data
David Watkinson (Director)
01732 377802
Devi Patel (Development Manager)
01732 377451
Maria Locke (Data Development Clerk)
Projects Director
Patrick Grice MRPharmS
01732 377296
Training Development Manager
Asha Fowells MRPharmS
01732 377463
Projects Administrator
Pauline Sanderson 01732 377269
Production
Katrina Avery 01732 377674
Group Publishing Director
Phil Johnson 01732 377633
Email
firstinitialsurname
@cmpmedica.com

Chemist + Druggist
news education tools

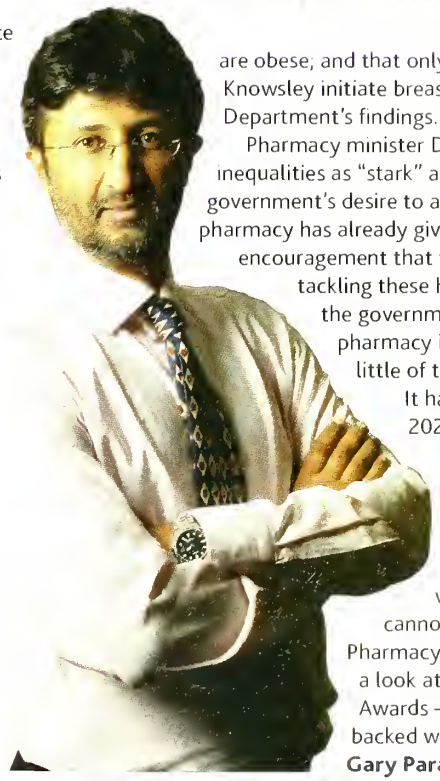
Comment from the Editor

From daytime TV and national newspapers to radio phone-ins and online forums, health stories regularly hit the headlines. This week was no different and it kicked off with the news that women can now buy the contraceptive pill from a UK-based website. Women who have already used the Pill can buy another three months' supply and get up to three morning-after pills from the online offering, which is run by doctors.

Whether you agree with the website or not frankly doesn't matter: the website exists and its proprietors believe there is unmet need, despite the thousands of GP surgeries and pharmacies that exist in communities up and down the country.

Perhaps this really should not come as a surprise. Data released by the Department of Health this week highlights the prevalence of health inequalities that exist in England, despite the significant amount of funding that has flowed into the NHS in recent years and the reforms and reorganisations we have witnessed in the primary care sector.

That more people die from smoking in the north of England than the south; that men and women in Kensington & Chelsea live around a decade longer than their counterparts in Manchester and Liverpool; that 16 per cent of reception year children in Hackney are obese, and that only a third of mothers in Knowsley initiate breastfeeding, are just some of the Department's findings.



Pharmacy minister Dawn Primarolo described the inequalities as "stark" and reiterated the government's desire to act. The white paper for pharmacy has already given community pharmacists encouragement that they have a role to play in tackling these health issues, but then so did the government's public health plan for pharmacy in 2005, and we have seen little of that actually come to fruition.

It has been suggested that by 2020 the NHS will be unable to cope with demand. If the minister is serious about tackling public health issues, then the white paper's promise to make PCTs into world-class commissioners cannot be fulfilled soon enough. Pharmacy is eager to engage – just take a look at the finalists of the C+D Awards – but the rhetoric needs to be backed with action.

Gary Paragpuri, Editor

Contents

Published Saturdays by CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE
C+D on the internet at: www.chemistanddruggist.co.uk
Subscriptions: Print and Electronic £240 (UK); £355 (Rest of World); Print only £210 (UK); £325 (ROW); Electronic only £180 (UK); £295 (ROW)
Circulation and subscription: CMP Information Ltd, Tower House, Sovereign Park, Lathkill St, Market Harborough, Leics. LE16 9EF
Telephone: 01858 468811
Fax: 01858 434958
Refunds on cancelled subscriptions will only be provided at the publisher's discretion, unless specifically guaranteed within the terms of subscription offer
The editorial photos used are courtesy of the suppliers whose products they feature. We are not responsible for the content of any external websites referred to in this magazine

GPs steal a march in COE debate

White paper proposals at risk from dispensing doctors as pharmacy fails to fight its corner

Sandra Gidley: "Absolute silence" from the profession over rule to prevent GPs dispensing close to pharmacies

BUILDING BRIDGES

Jennifer Richardson

Pharmacists must lobby their local MPs to avoid dispensing doctors skewing the debate on control of entry (COE) regulations, MP Sandra Gidley has warned.

Doctors have had considerable success in promoting their concerns over white paper proposals, which would prevent dispensing from practices too close to a pharmacy. C+D is aware of at least four written ministerial responses and one debate on the subject in the House of Commons in the past fortnight.

In contrast, Lib Dem shadow health spokesperson Ms Gidley said there had been "absolute silence" from the pharmacy profession. "My message to the profession would be: if you sit back and let them make all the running, then we could go backwards with dispensing doctors," she added.

"You have to make people understand the other side of the argument."

White paper listening events, which have been held by the DH around the country since the blueprint's publication in April, have also been heavily attended by dispensing GPs, she added.

She warned the profession: "Unless we're out there giving the other side of the story the debate could be taken in the wrong direction."

Joining C+D's Building Bridges campaign to get as many politicians as possible to visit their local community pharmacies would be a "very good way" to get MPs' attention, Ms Gidley added.

Sign up for Building Bridges at **www.chemistanddruggist.co.uk/buildingbridges**

Fight for village pharmacy

East Sussex villagers are fighting to save a community pharmacy threatened by a dispensing doctors application.

The decision of East Sussex Downs & Weald PCT to grant a Newick practice dispensing rights has caused "a huge furore", Lewes Lib Dem MP Norman Baker told the Commons.

The PCT said in considering applications it was not permitted to take into account any potential impact on local traders. The decision "must be based purely on whether any new service will prejudice general pharmaceutical or medical services", it added.

Lloydspharmacy has lodged an appeal against the decision. And local parish councils and residents have rallied behind the village's pharmacy – Mr Baker has presented a 2,000-strong petition against the dispensing practice contract on their behalf.

Villagers were concerned that a dispensing practice would "fatally undermine" the viability of the Lloydspharmacy branch.

Flick Johnson, East Sussex LPC secretary, said: "Virtually the entire population of Newick have signed a petition objecting to the application... there is no need for doctor dispensing." **JR**

Concern over drug price cuts

Pharmacy leaders have continued to express concern about the impact of branded drugs price cuts on pharmacies.

PSNC, independent representatives and several multiples have echoed the Company Chemists' Association's anxiety (C+D, June 21, p5) about how a 5 per cent reduction in branded medicines' costs to the NHS would be implemented. Repercussions for stock shortages, parallel imports, discounts and cash flow were the possible fall-out from the government's renegotiation of the PPRS (Pharmaceutical Price Regulation Scheme) with manufacturers, they said.

The agreement was "bad news for pharmacy", said Numark [illegible] managing director John D'Arcy. But, in a statement, RPSGB director of practice and quality improvement David Pruce said the agreement was "a winning situation for all concerned". However, he later clarified to C+D that this was a "global perspective" of NHS costs and medicines access.

PSNC said it would need to make sure the impact of any changes was calculated and accounted for. **JR**

How will pharmacy fare under the PPRS?
jrichardson@cmpmedica.com

PPRS 'too hasty', MP says

Shadow health minister Stephen O'Brien has condemned the government for reopening negotiations on the PPRS earlier than planned. Speaking at the BAPW annual conference, he said he was concerned about the "upheaval" caused to pharmacy by starting discussions before 2010.

He said: "There is a risk in moving too quickly to change a system which has suited the NHS and patients for 50 years."

No end in sight for distribution deals and fuel price rises
See p10 for full BAPW roundup

Come on over Valerie: Aberdeen-based Valerie Sillito celebrates her 2008 Community Pharmacist of the Year prize at last week's inaugural C+D Awards in London. The Boots consultant pharmacist was presented the prize by sponsor John Beighton of Teva. See p26 for more photos from the event

Scotland scores public health services hat trick

Government backs extended pharmacy role with 'significant' funding

Max Gosney

Scottish pharmacists have secured "significant" government funding to launch stop-smoking, emergency hormonal contraception and chlamydia advice services.

Payment details for the public health services remained undisclosed as C+D went to press.

However, Community Pharmacy Scotland (CPS) said the Scottish government had put up a considerable sum as part of the 2008-09 contract package due to be announced later this month.

Harry McQuillan, chief executive at CPS, called the health initiative "great news" for the profession. He said: "It shows the public health service element of the contract continues to evolve, recognising the expertise, professionalism, skills and commitment of community pharmacists."

Scottish minister for public health Shona Robinson said pharmacists were poised to make an "important contribution to improving the health of Scots".

She said: "By making them [extra services] part of the national community pharmacy contract we ensure Scots around the country can benefit from an equally high standard of care."

Pharmacists would begin introducing smoking cessation services from next month, the Scottish government said. Sexual health services are set to start from September. CPS said it was confident all three services would be available by the autumn.

The move signals an expansion of the public health service element of the Scottish pharmacy contract. Pharmacists are currently paid to provide core activities around promoting healthy living to patients.

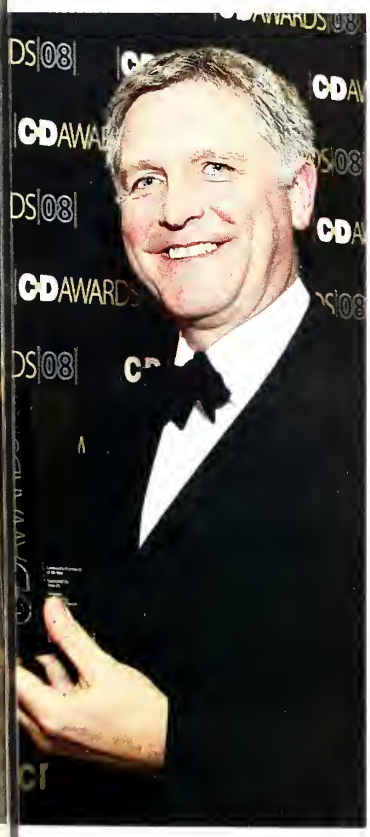
England looks on with envy

Pharmacy leaders in England applauded the roll-out of public health services in Scotland as their efforts to secure national funding continue to be frustrated.

Rob Darracott, CCA chief executive, said: "This is great news for Scottish contractors... it shows the impact of a strong national commitment to pharmacy."

The CCA is one of several pharmacy bodies to push for a nationally funded pharmacy minor ailments service south of the border. However, Westminster has so far resisted the calls, opting instead for locally led commissioning.

PSNC's Alastair Buxton said: "We will continue to make the argument that we'd like to see as many nationally funded services as possible."



PSNC frustrated as DES discussions stall

PSNC is "treading water" waiting to begin negotiations with the Department of Health on directed enhanced services for pharmacy.

The government pledged in the pharmacy white paper that it would use the directions, in consultation with NHS Employers and PSNC, to ensure PCTs commissioned certain services from pharmacy. They said this would begin in spring 2008. But Alastair Buxton, head of NHS services at PSNC, told C+D: "We're waiting with bated breath to start these discussions... we're treading water."

Industry insiders expressed disappointment at the news. Rob Darracott, chief executive of the Company Chemists' Association, said: "If we're not careful, this will be a huge missed opportunity." And John D'Arcy, interim managing director at Numark, said he hoped the white paper plans would not just be "good intentions and a lack of action".

Mr Buxton said he hoped negotiations would begin soon but that he was "conscious we are starting to enter the peak holiday season".

The DH said it had heard views on how the directed enhanced services might work at listening events in May. They said they would invite PSNC to discuss the plans "in due course". **ZS**

What services would you like to be directed?
zsmeaton@cmpmedica.com

News in brief

Public health woes

PCTs' failure to commission pharmacy public health services is a "missed opportunity" to address health inequalities, the CCA has said. The association hoped increased PCT access to health inequality data, announced by the DH this week, would encourage them to collaborate with pharmacy.

Co-op distribution

The Co-operative Pharmacy is investing £15 million in a wholesale distribution centre to serve all its 800 UK branches. It is hoped staff at an existing Sants distribution centre, operated by United Co-operatives prior to the merger with The Co-operative Group last year, will transfer to the Staffordshire depot.

ProScript compliance

Rx Systems has achieved compliance for the acute medication service (AMS) after testing in Scottish pharmacies. The supplier says it is on target to upgrade all current ProScript users in Scotland this month. AMS is the first core service of the ePharmacy programme in Scotland.

Flu PGD secured

AAH has launched a flu vaccination service for Healthwatch customers, to be offered under a private patient group direction. Pharmacists could earn around £1,500 if they deliver 25 vaccines per week during the flu season, AAH said. www.chemistanddruggist.co.uk

Pharmacy school opens

The University of East Anglia's School of Pharmacy is due to officially open on July 11. Guests include the chief pharmaceutical officer for England, Dr Keith Ridge.

News in brief

Stop-smoking scheme

Pharmacists will offer NRT and carbon monoxide tests in a Scottish government scheme to reward smokers in deprived areas who give up with money to be spent on fresh food.
www.chemistanddruggist.co.uk

Just ask about summer

More than 30 Fife pharmacies have been encouraging people to 'Just Ask' about summer health – including sunburn, rashes, stings and vaccinations – as part of a week-long campaign ending tomorrow (June 29).

LPCs chase stardom

LPCs have been sent advice on how to get more coverage in the local media. Prepared by a public relations agency, the guide offers tips on how pharmacists can use the 60th anniversary of the NHS to get key messages across about services being provided.
www.psnc.org.uk

Gorman a great fellow

Professor Sean Gorman, head of the School of Pharmacy at Queen's University, Belfast, has been made a fellow of the PSNI. NI's chief pharmacist Dr Norman Morrow said that professor Gorman had "helped to make us conspicuous on the international pharmacy map".

Online Pill no threat to pharmacy, says doctor

Website will look to signpost patients to pharmacies for further health advice

Rob Finch/Max Gosney

A website that bypasses pharmacy to sell the Pill directly to patients should not be seen as a rival by the profession, according to a director behind the project.

The service, launched in the UK last week, came under fire from industry representatives who claim the service could mean patients miss out on key health advice from pharmacists.

However, Dr Thomas Van Every, medical director at DrThom, which runs the service, told C+D: "We are big supporters of trying to get patients to go to pharmacy. We're actively looking to engage with the profession."

DrThom can provide three months' supply of oral contraceptive to women who have previously taken the Pill. Prescriptions are sent by special delivery after women complete an online questionnaire and speak with a doctor.

The RPSGB said it recognised benefits to the service, but warned that by not visiting a pharmacy, women could miss out.

Bitter Pill: RPSGB is concerned that ordering the Pill online means women will not be monitored adequately

Priya Sejpal, the Society's head of professional ethics, said: "As with all medicines, contraceptive pills can have complications and side effects. It is important that anyone prescribed contraceptive pills is monitored."

DrThom said it advised women seeking ongoing EHC prescriptions to have blood pressure checks carried out at local pharmacies.

The company had also teamed up with pharmacists to promote private prescriptions for erectile dysfunction and male pattern baldness, Dr Van Every stressed.

He said: "We think it's a very good model. My impression is that pharmacists barely have time to open their mail. If they can delegate some of the work to one of our doctors then it makes sense."

DrThom was launched in 2002 to offer sexual health advice and treatment online. The company employs 10 doctors, according to Dr Van Every.

DrThom: is it an opportunity or threat?
mgosney@cmpmedica.com

Convention offers CamRx members guide to clinical service success

Pharmacists should "future proof" their pharmacies in a bid to push ahead with implementing the white paper, according to industry insiders.

Speaking at this year's CamRx members' convention, Steve Lutener, head of regulation at PSNC, described how contractors could start to think about the clinical services outlined in the white paper. And Rajni Hindocha, managing director of pharmacy development group CamRx, said early planning would help contractors to make the shift from a supply role to an advisory one.

Mr Lutener said still more needed to be done to make sure "[illegible]s understand that MURs are not just a drain of £27 a time but actually provide benefits".

With refits, pharmacists should ensure consultation rooms were "future proofed", he said. For example, facilities such as sinks and computer links could enable contractors to provide new services in them. And pharmacists should learn to use the wider pharmacy team in service delivery, and ensure their pharmacies have a professional image.

Mr Lutener also warned pharmacists of the dangers of disclosing information about patients inappropriately, saying they could lose the right to access patient records if they were seen to be a security risk. **ZS**

Web pharmacy plans unveiled

CamRx is boosting its offering over the next year with services such as a new website and an 'e-pharmacy' that will allow patients to order prescriptions from members online.

Rajni Hindocha, managing director of the pharmacy development group, said enabling patients to order medicines online was important as internet trading continued to grow.

Mr Hindocha added that the group would be looking to assist members with "new challenges" such as the white paper and EPS release 2.
www.camrx.co.uk

Cat M fight goes to DH

A young pharmacist has written to the DH and PSNC about his concerns over category M.

Carter Chemist's Hatul Shah suggested that permitted generics purchase profits should be increased from £500 million, to reflect the current "credit crunch" resulting in increased utilities and delivery costs.

In response, PSNC explained that cost increases were factored into the global sum of pharmacy funding, but added into elements such as practice payments and MURs rather than purchase profit.

Independents' staffing stability was valuable to commissioners and patients, PSNC added, offering opportunities to build relationships in service provision.

Read the letter at www.chemistanddruggist.co.uk/news **JR**

The Care Summer skin range.
TLC that looks after you as well as your customers.

Sunburnt, dry or chapped skin? Minor burns and abrasions? The Care summer skin range includes Calamine Lotion, Aqueous Calamine Cream, Aqueous Cream and Antiseptic First Aid Cream. It's a range of TLC your customers will love you for.

For more information about the Care skincare range, please call 01484 848 200 or ask your local sales representative.

Care™

All the care you need.

Dispensary TALK

When did you last have a business meeting with your GP?

"Last month – we talked about CFC-free inhalers and about substance misuse patients – some of our methadone clients. We're going to meet more often in the future as I'm going to start doing some medicines management work."
George Romanes, GLM Romanes Pharmacy, Duns, Berwickshire

"I met with both surgeries two weeks ago. It was a one-off meeting about repeat dispensing. I was trying to push the fact that it will be beneficial for both."
Shirley Cox, Assura Pharmacy, West Everton, Merseyside

WEB VERDICT:

Within the last two weeks	29%
Within the last month	6%
Within the last six months	12%
Six months to a year ago	0%
More than a year ago	53%

Armchair view: Do you either love 'em or hate 'em? It seems perhaps we need to do more than send them a Christmas card every year? Maybe common ground can be found during a meeting at the local golf course?
This week: Have you got a business plan for your pharmacy? Let us know: pharmacy.editor@chemistanddruggist.co.uk

Big pharma set for supply chain shake-up?

More manufacturers may look to go their own way, BAPW conference hears

Emma Wilkinson

One way traffic: drugs companies will take greater control over product supply, consultancy firm claims

The big pharmaceutical companies are all likely to take greater control of products supplied to pharmacy, according to a consultancy firm.

Omar Sawaya, a senior associate at Booz & Company, said companies including Eli Lilly and Johnson and Johnson (J&J) could all make changes to medicine distribution.

However, some of the smaller drugs companies may not follow suit, Mr Sawaya told delegates at the British Association of Pharmaceutical Wholesalers (BAPW) annual conference in Chester last week.

Wholesalers would have to be flexible and adapt their businesses to survive in the new marketplace, Mr Sawaya warned. He said: "In any turmoil there is opportunity, it depends how you look at it.

"Wholesalers need to identify appropriate new revenue streams – they have a role to play in the evolution of these supply chains."

Mr Sawaya told delegates that moves by manufacturers to limit the number of wholesalers supplying products had been misunderstood. He said: "It's not an attempt by pharmaceutical companies to destroy the European wholesalers, and DTP will not be used to supply pharmacies selectively, that's just not good business sense."

BAPW chief executive Martin Sawer said the message would not go down well with everyone.

"Some are embracing the changes and are looking to different business opportunities and pan-European working but the question is what's going to happen to regional wholesalers who drive competition in the UK."

Eli Lilly said it was "looking into its distribution of products, however, no decision had been made". J&J was unavailable for comment as C+D went to press.

Novartis became the fifth drugs firm to pull out of the traditional supply chain earlier this month.

Pharma companies have claimed limiting supply via selected wholesalers will provide greater protection against counterfeits and help them get closer to pharmacists.

Fuel surcharges spark talks

Wholesaling chiefs will meet with PSNC to discuss how pharmacists can reclaim fuel levies passed on to them by an industry feeling the strain of spiralling fuel prices.

Martin Sawer, executive director at the BAPW, told C+D: "Wholesalers don't want to alienate their pharmacy customers. We want to know if there are any rules or regulations, which may allow them to claim fuel surcharges back."

Phoenix introduced a £9.75 a month fuel levy for pharmacy customers this February. Rival wholesalers have refused to rule out a similar move as average UK diesel prices hit 131.7p per litre this month, according to the AA.

Mr Sawer predicted further surcharges for pharmacists as wholesalers struggled to absorb the extra price rises. He had been prompted to discuss the situation with PSNC after a meeting of BAPW council members last week.

PSNC told C+D there is no present system for reclaiming a fuel surcharge. The organisation said it was in discussion with the Department of Health on the topic.

Mark James, group managing director for AAH PHarmaceuticals, said: "AAH has not introduced a fuel surcharge... however, clearly there are limits to the degree to which wholesalers will be able to continue to absorb these direct costs increases." **EW/MG**

Should pharmacists pay for fuel costs?
mgosney@cmpmedica.com

Dealing with devolution

Pharmacy needs to put pressure on the devolved governments in order to minimise the impact of differing health policies on the supply chain, delegates at the BAPW annual conference heard.

Alex MacKinnon, head of corporate affairs for Community Pharmacy in Scotland, said it was time for "active political lobbying". He said: "Wholesaling can often be the invisible part of the supply chain and government does take it for granted. We need to work with government to influence the strategic direction of health policy."

The contract, pay and action on public health were all areas where Scotland was taking its own direction, he said. Generic substitution and generic branding were also concerns, he added. **EW**

PROBLEM DANDRUFF?

Trust the No.1seller*

Neutrogena®T/Gel®Therapeutic Shampoo with Neutar™ solubilised coal tar extract is the No.1 selling medicated shampoo. Neutar™ technology helps support customer compliance by offering the proven efficacy of coal tar, but with an acceptable fragrance. So let dandruff sufferers experience the difference.

Recommend the No.1 seller. Recommend T/Gel® Therapeutic Shampoo.

*3 month (Feb - Apr 08) IRI Total HBA All Outlets IRI value sales data. 125ml T/Gel™ Therapeutic Shampoo.

Product information.
Name: Neutrogena T/Gel® Therapeutic Shampoo, containing Neutar™ Solubilised Coal Tar Extract 2.0% (equivalent to 0.5% coal tar). **Indication:** Treatment for seborrhoeic dermatitis, dandruff and scalp psoriasis. **Dosage:** Apply liberal amounts of T/Gel and massage into wet scalp. Leave on scalp for several minutes, rinse, repeat application, then rinse thoroughly. The shampoo can be used daily **Contraindications:** Hypersensitivity to Coal Tar. **Precautions:** Do not apply to acutely inflamed or broken skin. For external use only. If irritation develops, discontinue use and consult physician. In rare instances, temporary discolouration of blond, bleached or tinted hair may occur. Avoid contact with eyes. **Side effects:** Tar products may very rarely cause photosensitisation, skin irritation and acne like skin eruptions. **Cost:** 125 ml RRP = £3.91 (ex VAT) 250 ml RRP = £6.37 (ex VAT). **Legal category:** GSL. PL number: 08874/0014 **PL holder** Johnson & Johnson Ltd, Foundation Park, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **Date of preparation:** February 2008.

www.tgel.com/uk

Neutrogena®

C+D &
Sominex
Promethazine Hydrochloride

TUTORIAL 42

OTC management of sleep disorders

OBJECTIVES

- To appreciate the significance of sleep disorders in our society
- To identify the causes of sleep disorder
- To know when to offer advice or OTC treatments, and when to refer the patient to their GP

Sleep disorders, or disruption of normal sleep patterns, may be temporary and resolved with simple advice and short-term OTC medication, but it can also be an indicator of more deep-seated problems.

Accredited by
THE COLLEGE OF PHARMACY PRACTICE

...a, C1b, C1f, C2a, C2c, TC1, TC4

Society as a whole now considers sleep to be far more important than it used to, and with good reason.

As many as a quarter of adults may have a sleep disorder that can cause excessive sleepiness during the day.[1] Poor or disturbed sleep may be due to a wide range of often unavoidable circumstances that arise in life, such as shift working, looking after a young baby or travelling, or may be due to conditions including insomnia, snoring and sleep apnoea.[2]

The consequences of poor sleep are serious. The Sleep SOS Report published by RoSPA in 2004 estimated that 20 per cent of motorway accidents were due to excessive sleepiness and that untreated cases of obstructive sleep apnoea were costing the NHS £432 million each year.[3] The negative effect of poor sleep on productivity and decision-making are equally well known, if less well defined.

Insomnia

Insomnia is defined as difficulty in falling asleep or staying asleep[4], and up to a third of us have the condition from time to time.[5]

It's more likely to cause problems in the over sixties, as the elderly spend many of their sleeping hours in shallow sleep from which they are more easily wakened. In addition, they often sleep for brief periods during the day, and these brief naps may reduce their need to sleep at night.[6]

Insomnia is also more often found in women than men.[7]

Worries due to deteriorating relationships, family illnesses, or problems at work or with money can be involved. Anxious or depressed individuals often have difficulty in either going to sleep, or wake in the early hours and find that they cannot return to sleep.

Worried individuals usually find that their sleep pattern returns to normal once the situation causing the anxiety is resolved, or when they become accustomed to their new circumstances.

Jet-lag and shift-work may also cause insomnia as they disrupt sleep patterns, but while it usually only takes a day or two to recover from the former, changing working patterns may prove more difficult.[8]

Other common problems may be allowing too much light into the bedroom, perhaps due to light-coloured curtains, or consuming too much caffeine or taking other stimulants before going to bed.[9]

In some people, drinking alcohol just before bedtime disrupts sleep in the second half of the night, leading to light sleeping and frequent waking from dreams.[10]

Women may experience insomnia associated with major hormonal changes, such as the menopause.[11]

Snoring and obstructive sleep apnoea

Snoring and obstructive sleep apnoea are extremely common. Snoring is a vibration that occurs as the upper airway narrows due to loss of tone in the airway structure, often due to age, obesity or alcohol consumption.[12]

The noise of snoring can have distressing consequences. Otherwise loving partners may be banished from the bedroom, and there may be marital disharmony.

Sleep apnoea sufferers are prone to falling asleep during the day. This may cause embarrassment at the thought of falling asleep and snoring on public transport and could have serious consequences for drivers.

Obstructive sleep apnoea has even more serious consequences. In this situation, the pharynx closes still further and prevents breathing – and the subsequent struggle for breath disturbs the sleeper.[13]

The consequences of the disruption include: hypertension; irritability; and impaired performance at work, at home and on the road, leading to mistakes and a much higher risk of road traffic accidents.

When treated, however, patients frequently show dramatic responses, and often return to a state of alertness and vitality they haven't known for years or even decades.

Questions to ask include:

- Does the patient have difficulty falling asleep, or are they waking in the night or in the early morning?
- Are life circumstances such as a young family or noise at night involved?
- Are anxiety, grief, depression or dementia possible causes? While grief or anxiety are more likely to cause short-term insomnia, depression and dementia are more serious underlying conditions that suggest a chronic problem requiring referral to a GP.
- Is snoring an issue? If there is snoring, does the individual's breathing stop and start frequently? If so, the patient may benefit from an assessment of possible obstructive sleep apnoea.
- Is the patient's nose blocked, perhaps by polyps or a diverted septum?
- Is pain a possible cause, and if so what is the cause?
- Does the patient have a condition that might interfere with sleep, such as hyperthyroidism or heart failure leading to breathing difficulties?
- What medication is the patient taking?

Assessment

Pharmacists, technicians and medicines counter staff have a number of issues to cover in discussing sleep disorders with patients, including their age, their symptoms, their history, possible contributory factors, sleep routine and medication they may be taking.

Hypnotics prescribed for the treatment of insomnia include short-acting benzodiazepines (temazepam, loprazolam, lormetazepam) and the so-called 'z-drugs' (zopiclone, zolpidem, and zaleplon). There is a well documented risk of tolerance and dependency linked to these drugs, and it may be necessary to refer to the GP if patients are taking benzodiazepines or have been taking Z drugs beyond their licensed treatment period of two to three weeks. Also, the sedating antihistamines available OTC have significant antimuscarinic activity and should be avoided in patients with glaucoma. Individual antihistamines have specific cautions and contraindications including CNS depressants, MAOIs and epilepsy.

Other medication that can interfere with good sleep includes antidepressants, decongestants, corticosteroids, appetite suppressants,[14] phenytoin and theophylline.[15]

Individuals suspected of having significant levels of anxiety, depression or possible dementia should be referred, as should those who are under 16 years, and those who complain of sleeping problems of more than three weeks' duration.

Management – insomnia

A good sleep routine can contribute to improving sleep, including establishing regular times for going to bed and for waking. There should be an hour or so of relaxation without meals or smoking before bed.

Naps should be avoided in the daytime, and not drinking anything containing caffeine after the early afternoon can make a big difference. It may help to reduce alcohol intake to one or two drinks a day. Any extraneous noises at night can be dealt with using earplugs.

Patients should also be advised that if they can't sleep, the best course may be to get up and go into another room to read quietly until they feel sufficiently sleepy that they are confident about going back to bed.[16]

Management – obstructive sleep apnoea

Perhaps the key interventions a pharmacist can make where appropriate are to advise the patient to reduce their weight and alcohol consumption.

Patients should be advised to avoid sedatives and sleeping tablets, as these further narrow the airways and worsen snoring and obstructive sleep apnoea. Non-sleepy snorers can also be advised to avoid sleeping on their backs.[17]

Other interventions that might be considered include tapes designed to relieve nasal obstruction, and mandibular advancement devices that can help patients whose snoring is generated from the base of their tongue, perhaps because of a recessive lower jaw.

However, individuals suspected of obstructive sleep apnoea should be referred to their GP for investigation and possible treatment using continuous positive airway pressure (CPAP) machines, or surgery to correct airway narrowing in the soft palate or nose.[18]

Medication

Sedative antihistamines such as 20mg promethazine hydrochloride and 25mg diphenhydramine are licensed to treat temporary sleep problems, and can be purchased over the counter as sleep aids. They typically shorten the time taken to fall asleep and reduce nocturnal waking, and should be taken 15-30 minutes or 20-30 minutes before going to bed, respectively.[19,20]

They should not be used for more than seven nights, as rebound insomnia can occur after prolonged use, and some patients may experience hangover symptoms in the morning.[21] Antihistamines should not be used for this purpose in children under the age of 16 years, except on medical advice.[19]

Some herbal remedies are licensed as sleep aids and typically contain valerian or passiflora as their main active ingredients. Details can be found in the C+D Guide to OTC Medicines.

Hypnotics such as zaleplon, zolpidem and zopiclone or benzodiazepines may be prescribed for insomnia, but patients should be warned they may cause drowsiness and can be addictive.[22]

References and Sominex product information are online at www.chemistanddruggist.co.uk/pharmacists

Pause for reflection

- Audit sales of sleep aids from the medicines counter for a week. Record the advice given or the action taken.
- Use your knowledge of sleep disorders and the pharmacy PMR records to identify patients who may benefit from an MUR. What criteria might you set for assessing suitability?
- Familiarise yourself with Information for Patients available from www.Prodigy.nhs.uk.

Test your understanding

Test your understanding by answering the following questions, then check your answers by phoning our Telephone Marking Service on **08705 800 287**. You will be asked for the Tutorial Number. This tutorial is No 42. Listen to the instructions and press buttons 1 or 0 to indicate your answer – "1" indicates true; "0" indicates false. Calls are charged at standard national rates.

This module will also appear on the C+D website, www.chemistanddruggist.co.uk, under 'Education' until July 26, 2008.

If you pass this module, and want the appropriate certificate for this College of Pharmacy Practice accredited tutorial, complete the form below and send the original (or a photocopy) to: Pharmacy Projects, CMPMedica Ltd, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE before August 9, 2008. Please enter your name, pharmacy, address, and phone number below:

Name:

Address:

Pharmacist ❑ Registration No

Technician ❑ Counter assistant ❑

Signature

1. Insomnia is defined as falling asleep regularly during the day.
❑ True ❑ False

2. A consistent sleep routine allows drinking small amounts of alcohol and eating certain foods close to bedtime.
❑ True ❑ False

3. Drinking alcohol may affect sleep in the second half of the night.
❑ True ❑ False

4. Antihistamines such as diphenhydramine and promethazine hydrochloride should be taken 30 minutes before bed to improve effectiveness.
❑ True ❑ False

5. Individuals suffering from insomnia may find their symptoms improve if they avoid drinking coffee and soft drinks from the afternoon onwards.
❑ True ❑ False

6. Antihistamines can be offered to adults and children over the age of 12 years to help with temporary sleep problems.
❑ True ❑ False

7. Patients who complain of snoring may find their symptom improves if they lose weight.
❑ True ❑ False

8. Patients who can't sleep can be advised to get up and read quietly for a while.
❑ True ❑ False

9. Patients with suspected obstructive sleep apnoea should not be advised to use sleeping tablets or sedating drugs.
❑ True ❑ False

10. Sedating antihistamines are now considered safe to use in all patients with glaucoma.
❑ True ❑ False

Are we ethically bankrupt?

Some pharmacists are more concerned about avoiding prosecution than making the best ethical decision. Perhaps an unsurprising position when we can still face criminal prosecution for making an error.

I feel a twinge of guilt about turning away requests for emergency supplies, but it is so much 'easier' and 'safer' to refer them to the local GP surgery or on-call doctor service. Why should I risk disciplinary proceedings and potentially the premature curtailment of my career?

Telling myself what a great professional I am is the only reward and it tends to wear a bit thin after a while. It's far too easy to simply pass the buck. GPs are better at managing these risks, partly because they're helping out a medical colleague, partly because they have better access to patient notes, and partly because they know that the GMC will support them if anything hits the fan.

A small study, published in the Journal of Medical Ethics, found that pharmacists are ethically 'inactive' even when other health professionals put patients at risk. This is usually due to overworked pharmacists taking the pragmatic option. Any pharmacist who reports every potential drug interaction to disinterested GPs is not going to get through their daily pile of prescriptions. And where do you draw the line at reporting possible interactions anyway?

Upsetting GPs is the quickest way to damage your business and there probably won't be any thanks from the patient either. It's simply not worth making waves.

Patients requesting supplies at X Pharmacy because they've delayed ordering their repeats are sent to their GP. How else do you prevent this becoming a regular occurrence? Of course, you'll weigh up the pros and cons of each request but there is always a risk the prescription request to the surgery will be refused and you may have already supplied the drugs. And I'm only likely to report a poorly performing health professional if their continued practice would involve me in disciplinary proceedings. Being a realist doesn't allow much space for ideological thinking.

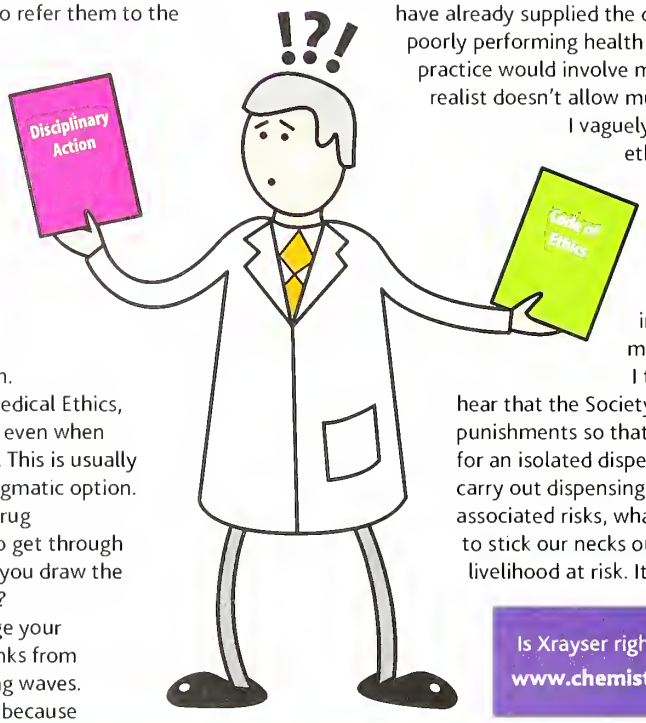


Illustration Jo Konopelko

I vaguely remember discussing the code of ethics at university and during my pre-reg year, but have barely opened it since. I saw its downsizing to a mere pamphlet from the more impressive A4 presentation as a further downgrading of its importance. It now disappears the minute I put it on the shelf.

I think we all heaved a sigh of relief to hear that the Society is lightening up on its draconian punishments so that we don't have to fear being struck off for an isolated dispensing error. But because we have to carry out dispensing we're forced to live with the associated risks, whatever they are. There is no incentive to stick our necks out because it unnecessarily puts our livelihood at risk. It really is time for change.

Is Xrayser right? Comment at **www.chemistanddruggist.co.uk/xrayser**

Doctors: prescription generators on a gigantic scale

I recently had a note arrive from my local PCT concerning excessive or inappropriate prescribing.

Am I the only one to be alarmed and annoyed that as our remuneration is cut to the bone (some would say into the bone) every day we witness tens of thousands of pounds worth of medication leaving the pharmacy with positive knowledge that some of it is probably unnecessary, horrendously costly to a cash-strapped NHS and that a fair chunk of it will probably end up back in the pharmacy for disposal.

Many of the pharmacies I have worked in have been so swamped with return medication that they have had to decline to accept any more until the next too infrequent visit from the waste contractor.

It may be a heresy to say so, but I frequently feel an annoyance and loss of respect for those doctors in general practice who appear to me to be prescription generators on a gigantic scale.

Surgeries have become prescription factories far removed from the targeted care system in which I grew up. Blunderbuss prescribing is now the order of the day, encouraged by the state, which believes everyone over a certain age should have medication to prevent them developing certain conditions, regardless of whether they are ever likely to get them in the first place. This is leading to the most appalling waste of scarce resources.

Why can't we more effectively target those people actually at risk and end the lottery of some unfortunate patients being unable to get the medication that they so desperately need for certain conditions, such as Alzheimer's or cancer, on grounds of cost? Yet that same patient will often be bombarded with statins, proton pump inhibitors, ACE inhibitors and heaven knows what else. These in total often cost far in excess of the drugs banned, as doctors and PCTs chase targets for preventative prescribing, which is claimed to be cost-effective in the long term but can lead to the most monumental waste imaginable.

Only a totally state-run, tax payer-funded healthcare system could possibly countenance such an inefficient system of prescribing. The concept, common abroad, that doctors prescribe responsibly for all their patients the smallest and least amount of medication in the lowest dose for the shortest possible time, is totally foreign to Britain's NHS.

I firmly believe that every patient with a defined medical condition should receive whatever medication is necessary, whenever they need it, regardless of cost. Then if there are any resources remaining, target those at risk, especially those with long-term needs.

But with an increasing population, is the day not coming when more effective, targeted prescribing will just have to be fitted into the increasingly limited resources available?

Doctors, politicians and patient groups may scream, but eventually something will have to give. We just cannot go on as we are.

Is Locum at Large right? Comment at **www.chemistanddruggist.co.uk/opinion**

Short of time?

Save your precious time with a weekly round up of all the latest pharmacy news and clinical content with our free email news bulletins.

"C+D is an essential tool in my daily life as a pharmacist as well as being a cracking good read"

David Morgan, Community Pharmacist

Register today!

www.chemistanddruggist.co.uk/register

Letters

Please email us with your letters to:

haveyoursay@cmpmedica.com

Or write to the Editor at:

C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

Letters may be edited for content and length

Central generic tendering: the Department must think again

The Pharmaceutical Contractors Committee has grave concerns about the Department's proposal for the central tendering of generic medicines in primary care.

We believe this proposal is misguided and ill-conceived and, worse still, officials seem intent on railroading it through with no regard for our legitimate concerns or for the risks to the supply chain that it poses. Contrary to the impression that has been given, the PCC has not at any stage been consulted on this proposal by the Department. We find that disappointing. Does the Department believe that the views of pharmacists and their representative body do not matter?

Pharmacy contractors in Northern Ireland are efficient and effective procurers of NHS medicines. The supply chain arrangements are secure, reliable and safe. Any proposal for radical change such as this needs to have been carefully developed, risk assessed and the case for change needs to be proven in advance. The Department made a similar change in relation to the supply of woundcare products in July 2007. That has resulted in 95 per cent of the woundcare products available in the UK not being available in Northern Ireland. That's bad news for the NHS and for patients in Northern Ireland, and it bodes ill for this even more radical proposal.

So we will oppose the plan for generics central tendering, and we appeal to the Department to stop and think again. We have commissioned an analysis and critique of the proposal from an independent world-leading expert. We look forward to discussing the outcome of that work with the Department. We hope they will be prepared to listen.

The generics central tendering proposal is only part of a wider picture. We have been seeking to make progress in negotiations with the Department over a new pharmacy contract. We are unimpressed by the Department's stance in those negotiations, which has resulted in progress being slower than we wanted. It means that the public who value their pharmacy so highly are being deprived of a new range of pharmacy services that can enhance their health and wellbeing.

We remain extremely concerned over the effects of category M. Pharmacy contractors in Northern Ireland are feeling the full force of category M price reductions and it is having a savage impact. That is unfair and unsustainable. We call on the Department to address this matter fully and as a matter of urgency.

We expect the Department to consult us and listen to our concerns over the generics central tendering proposal. We remain willing to work in collaboration with the Department on issues concerning the new contract and on category M, but collaboration is a two-way process and we need to know that they are prepared to listen and act on our concerns.

I will be writing to all contractors in Northern Ireland shortly to provide an update and more details on each of these matters.

Terry Hannawin,
chief executive, Pharmaceutical Contractors Committee

... the DHSSPS responds to PCC

We are extremely disappointed at the position taken by the PCC in this statement. We have been encouraging a collaborative approach to a range of developmental initiatives and unfortunately a number of inaccuracies in the statement have the potential to mislead.

We will be taking up with the PCC all of the points raised in their statement.

The Department places the highest priority on the modernisation and development of community pharmacy services. We look to the new contract as the key vehicle for delivering these.

We have made strenuous efforts to work with the PCC in the context of the new contract and have, for example, made numerous offers over the course of the past year on the development of patient-focused services. All of these offers have been rejected.

The health minister, Michael McGimpsey, is now taking a keen interest in the contract and is on record as saying that he wished to see rapid progress being made.

DHSSPS spokesperson

Come on, MURs are not difficult

Cat M is a sound idea but needs some adjustments to make it work

Read Jatul Shah's view on category M at chemistanddruggist.co.uk/letters

I work for a large multiple as a branch pharmacist and have to comment about your article on MURs (C+D, June 7, p10).

MUR money is not new money. This is money that was taken away from contractors and offered back in return for a simple intervention (the MUR). It is not a difficult process and the new forms have hugely improved the paperwork side of things. The government made it absolutely clear that MURs are to become a basic part of any pharmacist's job. The 400 annual maximum will be used as a target by companies – if it was your own business you would do the same.

Nobody is kicking up about having to follow SOPs, or enhanced services, so why the fuss about being asked to perform two 10-minute consultations each day? Most locums seem able to find time to make phone calls and read papers, some even find time to leave the pharmacy unattended while they "nip out for lunch".

To describe the process of support and encouragement to do MURs as bullying is ridiculous. If you turned away prescriptions because you couldn't be bothered to do them, you would expect to be disciplined so why not do the same for MURs?

It is high time pharmacists acted like professionals, stopped whining, and accepted MURs are a part of the job, not extra.

Antony Marshall MRPharmS
Stoke-on-Trent

What concerns the CCA are the double standards of the DH...

Read Georgina Craig's view on commissioning services at: chemistanddruggist.co.uk/letters

NEW

A communication by Procter & Gamble Pharmaceuticals

A fast route to symptom relief for moderate ulcerative colitis (UC) patients with new Asacol® (mesalazine) 800mg MR tablets dosed at 4.8g/day: what pharmacists need to know

Asacol (mesalazine) 800mg Modified Release (MR) tablets are now available on prescription. We asked Hannah McNally, Clinical Pharmacist, what pharmacists need to know about this new treatment option for patients with ulcerative colitis (UC) and Crohn's disease (CD):

Q. What type of patients will be prescribed Asacol 800mg MR tablets (dosed at 4.8g/day)?

A. Asacol 800mg dosed at 4.8g/day is indicated for patients suffering from moderate active UC.

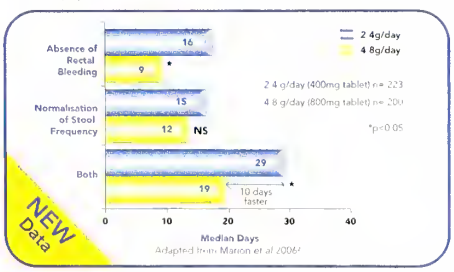
Asacol 800mg dosed at 2.4g/day is indicated for mild acute exacerbations of UC and up to 2.4g/day for the maintenance of remission therapy in both UC and Crohn's ileo-colitis patients.[1]

Q. What are the patient benefits of Asacol 800mg MR tablets dosed at 4.8g/day?

A. The ASCEND (Assessing the Safety & Clinical Efficacy of a New Dose of 5-ASA) I and II clinical trials evaluated overall treatment success as the primary endpoint. Additional results showed that Asacol 800mg MR tablets given at 4.8g/day provide symptom relief* 10 days faster (median time) than a mesalazine 400mg at 2.4g/day for moderate UC patients (figure 1).[2]

*Symptom relief is defined as both absence of blood in the stool and normalization of stool frequency

Figure 1
Median Time to Symptom Relief: (ASCEND I and II pooled moderate population)



Time to symptom relief: the number of days from the first day of dosing to the first day of symptom relief
Median time is the time for 50% of patients to experience symptomatic relief

The new dose of 4.8g/day also provides a significant improvement in quality of life at three weeks for moderate UC patients (as a mean change from baseline).[3]

Q. If I don't have any Asacol 800mg MR tablets in stock, can I give the patient Asacol 2x400mg MR tablets instead?

A. No. Interchangeability between Asacol 400mg MR tablets and the new Asacol 800mg MR tablets has not been established. According to MIMS, different mesalazines are not interchangeable and should be prescribed according to their mode and site of action with the brand name specified.[4]

In addition, for moderate acute exacerbations of UC only Asacol 800mg MR tablets are licensed for dosing up to 4.8g/day.[1] Asacol 400mg MR tablets are only licensed for doses at 2.4g/day for these patients.[5] Asacol 400mg MR tablets are not licensed at 4.8g/day.

Q. Will most moderate UC patients be switched from Asacol 400mg MR tablets to Asacol 800mg MR tablets (at 4.8g/day) or should I stock both doses?

A. Different mesalazines are not interchangeable[4] and it is advisable to stock both doses. Moderate UC patients will not be automatically swapped to Asacol 800mg MR tablets (dosed at 4.8g/day) as every patient is different and has different requirements from their treatment.

Asacol 400mg MR tablets will still be available. UC or CD patients who are being successfully treated and are in remission should be maintained on this dose of Asacol 400mg MR tablets and not be switched to Asacol 800mg MR tablets. Asacol 800mg MR tablets may be prescribed for newly diagnosed patients and the higher dose of 4.8g/day may also be considered for those moderate UC patients suffering from flares in order to help achieve fast symptom relief.

Q. How should Asacol 800mg MR tablets be dosed?

A. Asacol 800mg MR tablets have the benefit of twice daily dosing,[1] thus avoiding the difficult lunchtime dose, which patients often forget to take. Divided dosing offers the convenience of twice daily dosing which is associated with better patient compliance[6] versus three times daily dosing.[7]

Q. Are there increased side effects with a higher dose?

A. There are no significant differences in the overall adverse event profile of Asacol 800mg MR tablets dosed at 4.8g/day at six weeks compared to mesalazine 400mg dosed at 2.4g/day.[8]

Q. How will Asacol 800mg MR tablets be packaged/dispensed?

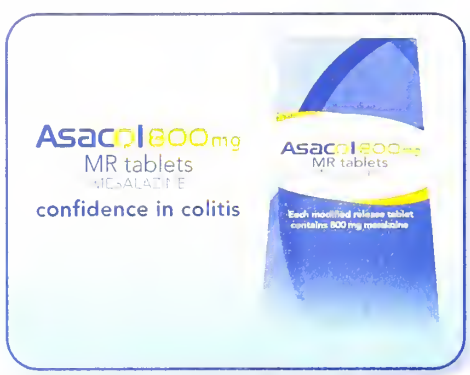
A. Asacol 800mg MR tablets will be packaged in bottles; each bottle will contain a total of 180 tablets.

Q. What are the costs associated with prescribing Asacol 800mg MR tablets (4.8g/day) compared to Asacol 400mg MR tablets?

A. Asacol 800mg MR tablets cost the same as Asacol 400mg MR tablets on a gram per gram basis. Based on treatment at 2.4g/day for one month (30 days), both Asacol 800mg MR tablets and Asacol 400mg MR tablets cost £62.43. Asacol 800mg MR tablets dosed at 4.8g/day will cost £124.86.**

Asacol 800mg MR tablets are available in bottles of 180 and cost £124.86**.[4]

**Price at time of publication



Adverse events should be reported to Procter & Gamble Pharmaceuticals UK Ltd on 01784 474900. Information about adverse event reporting can be found at www.yellowcard.gov.uk

Date of preparation April 2008
AS7677/57007

P&G Pharmaceuticals

Asacol® 800mg MR Tablets Abbreviated Prescribing Information
Presentation: Asacol 800mg MR Tablets, PL 00364/0083, each modified release tablet contains 800mg mesalazine (5-aminosalicylic acid). Product is supplied in plastic (HDPE) bottles containing 180 tablets (£124.86). **Indications:** Ulcerative colitis: Treatment of mild to moderate acute exacerbations. For the maintenance of remission. Crohn's ileo-colitis: Maintenance of remission. **Dosage and administration:** Adults: Mild acute exacerbations: 3 tablets a day in divided doses. Moderate acute exacerbations: 6 tablets a day in divided doses. Maintenance of remission of ulcerative colitis and Crohn's ileo-colitis: Up to 3 tablets a day, in divided doses. **Elderly:** The normal adult dosage may be used unless renal function is impaired. **Children:** Not recommended. **Contra-indications:** A history of sensitivity to salicylates or renal sensitivity to sulfasalazine. Confirmed severe renal impairment (GFR less than 20 ml/min). Hypersensitivity to any of the ingredients. Severe hepatic impairment. Gastric or duodenal ulcer, haemorrhagic tendency. **Precautions:** Use in the elderly should be cautious and subject to patients having a normal renal function. Discontinue treatment immediately if acute symptoms of intolerance occur including vomiting, abdominal pain or rash. Patients with the rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine because of the presence of lactose monohydrate. Standard haematological indices (including the white cell count) should be monitored repeatedly in patients taking azathioprine, especially at the beginning of such combination therapy, whether or not mesalazine is prescribed. Asacol should be used in extreme caution in patients with confirmed mild to moderate renal impairment. Renal function should be monitored (with serum creatinine levels measured) prior to start of treatment, and periodically during treatment, taking into account individual history & risk factors. Mesalazine should be discontinued if renal function deteriorates. If dehydration develops, normal fluid & electrolyte balance should be restored as soon as possible. Serious blood dyscrasias (some with fatal outcome) have been very rarely reported with mesalazine. Haematological investigations including a complete blood count may be performed prior to therapy initiation and immediately if the patient develops unexplained bleeding, bruising, purpura, anaemia, fever or sore throat. Stop treatment if suspicion or evidence of blood dyscrasia. Lactulose or similar preparations which lower stool pH should not be concomitantly administered. Concurrent use of other known nephrotoxic agents, e.g. NSAIDs & azathioprine, may increase risk of renal reactions. Mesalazine should therefore be used with caution during pregnancy and lactation when the potential benefit outweighs the possible hazards in the opinion of the physician. If neonate develops suspected adverse reactions consideration should be given to discontinuation of breast-feeding or discontinuation of treatment of the mother. **Undesirable Effects:** Common: nausea, diarrhoea, abdominal pain, headache, vomiting, arthralgia/myalgia. Rare: reports of leucopenia, neutropenia, agranulocytosis, aplastic anaemia, thrombocytopenia, myocarditis & pericarditis, peripheral neuropathy, vertigo, bronchospasm, eosinophilic pneumonia, pancreatitis, alopecia, lupus erythematosus-like reactions and rash (inc. urticaria), bullous skin reactions, abnormalities of hepatic function and hepatitis, interstitial nephritis and nephrotic syndrome with oral mesalazine treatment: usually reversible on withdrawal. Renal failure has been reported. Suspect nephrotoxicity in patients develop ng renal dysfunction. Drug fever. Very rarely, mesalazine may be associated with exacerbation of the symptoms of colitis. Stevens-Johnson syndrome & erythema multiforme, interstitial pneumonitis. **Legal category:** POM. **Marketing Authorisation Holder:** Procter & Gamble Pharmaceuticals UK Ltd, Egham, Surrey TW20 9NW. Asacol is a trademark. © 2007 Procter & Gamble Pharmaceuticals. Refer to Summary of Product Characteristics before prescribing. Date of preparation November 2007. AS7555.

References: 1. Asacol 800mg tablets Summary of Product Characteristics. 2. Marion JF *et al. Gut* April 2006, Suppl 2, Vol **55**, Abstract 140. 3. Data on file, Procter & Gamble Pharmaceuticals. 4. MIMS – Monthly Index of Medical Specialties (MIMS) UK, April 2008, page 212. 5. Asacol 400mg tablets Summary of Product Characteristics. 6. Carter *et al. Gut* 2004; **53** (Suppl V): v1-v16. 7. Greenberg RN. *Clin Ther* 1984; 6(5): 590-599. 8. Hanauer SB *et al. Gut* April 2006; Suppl 2, Vol **55**, Abstract 303.

C+D Clinical

The elderly: common problems

The latest in a series of picture guides considers conditions likely to affect elderly patients

Reflect

Which skin conditions are more prevalent in elderly people? What does lentigo maligna look like? How does seborrhoeic keratosis differ from actinic keratosis?

Plan

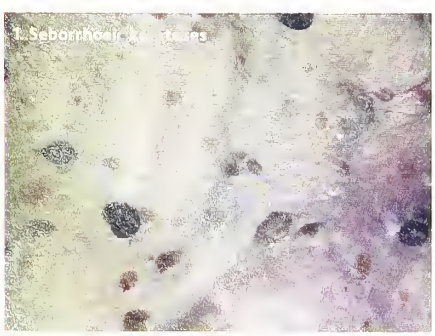
This picture guide will help you to identify some skin and eye conditions that become more common with age.

CPD This article can help in the following CPD competencies: **G1a, G1c, G1d, G1v, C1a, C1f, C3b**. See http://tinyurl.com/68ox7b

Dr Nigel Stollery

Some of the conditions covered in this article are seen in all age groups but are more common in the elderly. Others are seen only in older people. Many of these are the result of the natural ageing of skin leading to dryness and can be managed in the community. Other conditions, such as cataracts, can have a significant impact on quality of life and everyday living, yet are easily treated once a diagnosis has been made. In many of these conditions, education in earlier life – especially regarding exposure to sunlight – can significantly reduce their incidence later on. Pharmacists are in an ideal position to help with this.

Seborrhoeic keratoses (see picture 1)

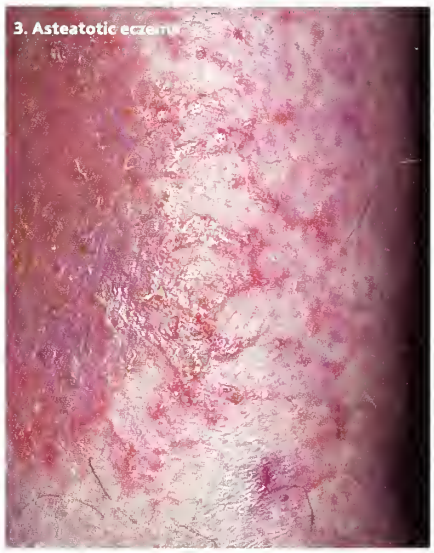


The incidence of seborrhoeic keratoses increases with age but may be familial with an autosomal dominant inheritance. They are common in white races and are usually asymptomatic. Males and females are equally affected and there is little chance of a spontaneous regression. The lesions can occur on any site and have a characteristic stuck-on appearance with a greasy keratin-rich surface. Colour can vary from yellow through to black, so they may be mistaken for melanomas. Although treatment is not always necessary, curettage or cryotherapy can be helpful. Cautery should be kept to a minimum to avoid scarring.

Actinic keratoses (see picture 2)

Also called solar keratosis, these result from sun damage and occur on sun-exposed areas. Unlike seborrhoeic keratoses, with their stuck-on appearance, actinic keratoses are more hyperkeratotic. The skin looks inflamed, feels rough to the touch and there is localised telangiectasia (dilation of blood vessels, creating local red lesions). Other causes include ionising radiation, radiant heat and exposure to tar or coal distillation products.

If left, actinic keratoses may resolve spontaneously, but approximately 1 per cent will undergo malignant transformation to squamous cell carcinomas. For this reason they are usually treated. Treatments include cryotherapy, curettage and cautery, topical diclofenac, or topical 5-fluorouracil. Patients also need to be advised to protect themselves from further sun exposure using hats and sunscreen, particularly with the increasing fashion of prolonged holidays abroad in the older age group.



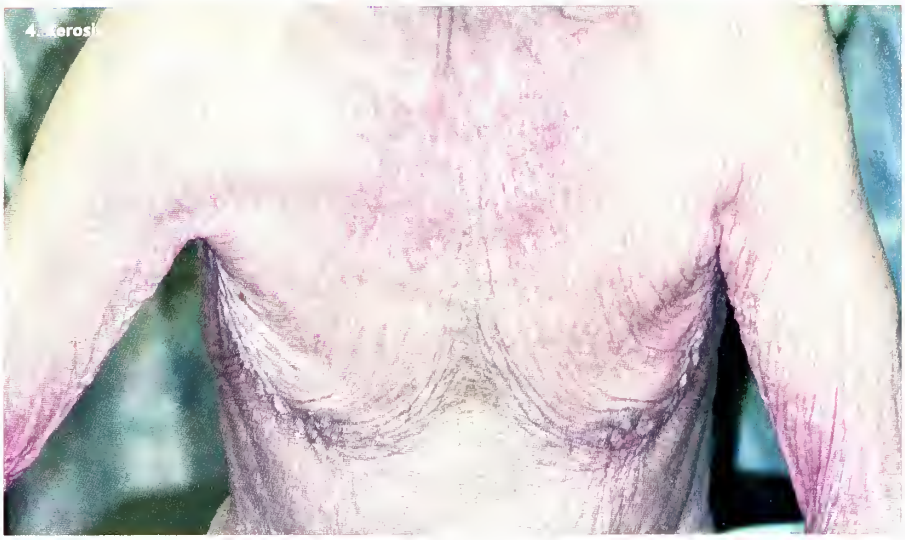
Asteatotic eczema (see picture 3, above)

Also known as senile eczema, this condition is the result of a reduction in the surface lipids of skin that occurs in the elderly. The condition is most common on the legs but it may also affect the arms. The skin is dry and has a surface scale with a typical crazy paving or eczéma craquelé appearance. The condition is worse in the winter and with increasing age.

Treatment includes avoiding very dry atmospheres (as with central heating) by

The College of Pharmacy Practice

This course (module 1443), in association with multiple choice questions being published in C+D July 5, provides one hour's continuing education



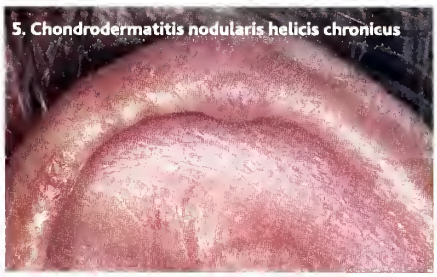
humidifying the air, avoiding wool and irritating fabrics, and applying liberal amounts of emollients to the skin on a regular basis. Products containing urea are particularly useful for promoting hydration. Long soaks in hot baths should be discouraged, as should the use of cosmetic bath additives.

Xerosis (see picture 4, above)

Skin has a tendency to dry naturally with age and will look and feel dry to the touch. The reason is not clear as water loss from the skin does not seem to increase with age, but the water content does reduce. The dryness tends to be worse in the winter with the lower limbs affected more than the rest of the body. Statins can make the dryness worse, as can certain medical conditions such as an underactive thyroid.

Emollients applied directly to the skin or as bath additives can be useful, though patients need to be warned that they can make baths slippery and increase the risk of falls. Soap, shower gels and bubble baths make dry skin worse and should be discouraged. Soap substitutes such as aqueous cream may be used in their place if required.

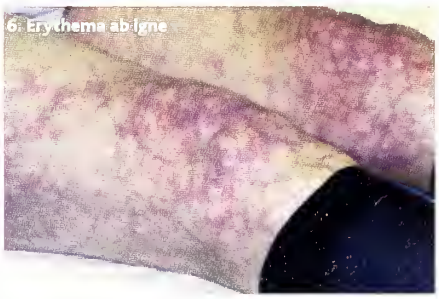
Chondrodermatitis nodularis helicis chronicus (see picture 5)



This condition affects the prominent edge of the ears and causes firm tender nodules, which may have a white colour when the skin is stretched. Patients find the pain is worse in cold weather and often report not being able to lie down with the affected ear on the pillow. The condition may affect one or both sides.

Treatment is not always necessary, but the differential diagnosis of squamous cell carcinoma means that biopsy is often undertaken. Where treatment is required the skin is usually cut over the affected areas after which the cartilage below is trimmed down and the skin closed.

Erythema ab igne (see picture 6)



Although this condition can occur at any age, the increased incidence of arthritis and joint pain in the elderly means that they are more likely to expose their skin to heat such as hot water bottles and radiators. After prolonged exposure the skin may develop the characteristic reticular net-like appearance. This is more common on the legs of women.

A single exposure to heat may cause a temporary rash but with increased exposure there is more chance of the rash becoming permanent. A similar rash can be seen with hypothyroidism, which should be excluded by performing a thyroid function test. The rash should also alert observers to the possibility of poor social circumstances and possibly hypothermia, which may require a social services or GP referral for advice and assessment.

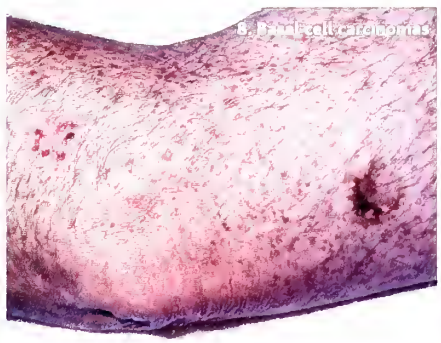
Hyperkeratotic horns (see picture 7, above right)

Related to actinic keratoses, hyperkeratotic horns are more common in the elderly, and may grow out from the surface of the skin.

In some cases they simply separate from the skin and can be removed. In other cases referral for excision may be appropriate.

In all cases, an underlying squamous cell carcinoma needs to be excluded. When horns are excised the base needs to be included and sent for histology. As horns are a sign of sun damage, advice should be given about suncare in the future including covering exposed areas of skin and use of sun protection products.

Basal cell carcinomas (see picture 8)



These are now the commonest type of skin cancer, and although they rarely metastasise and have a fatal outcome, if left untreated they can cause significant morbidity and distress. Various forms exist including the nodular type (also called a rodent ulcer because of its similarity in appearance to a rat bite), which has a typical rolled pearly edge and central ulceration and is more common on sun-exposed areas. The superficial type resembles an area of localised psoriasis, while the morphoeic type looks like a scar with ill-defined edges. The pigmented form is seen more commonly in darker-skinned individuals.

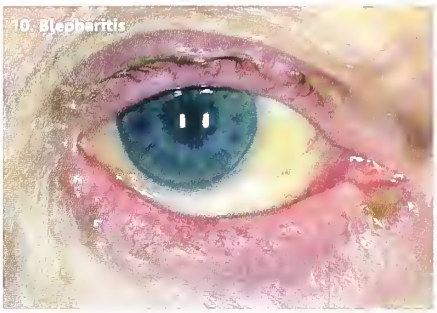
Diagnosis can be difficult, so if in doubt refer to a GP for confirmation. In many cases this may require a biopsy either in primary or secondary care. After diagnosis of a BCC, the risk of having more is increased, so extra vigilance is important, as is protection from the sun.

Lentigo maligna (see picture 9, overleaf)

With increasing age, patients are more likely to develop areas of increased pigment in sun-exposed parts of the body such as the face or scalp. The majority of these will be simple solar lentigenes and no treatment is required. However, in some

cases the diagnoses will be lentigo maligna or Hutchinson's malignant freckles. To differentiate between the two, a biopsy is usually undertaken after which treatment of choice is excision or cryotherapy in the very elderly. If left the areas may develop into lentigo maligna melanoma.

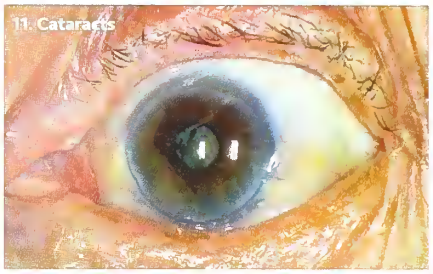
Blepharitis (see picture 10)



Blepharitis is one of the commonest causes of a red eyelid margin and increases in incidence with age. It is more common in those with a history of greasy skin, dandruff, acne rosacea and seborrhoeic dermatitis. The eyes are typically dry, red, and may itch or burn and there may be a visible surface scale-like dandruff around the lashes.

Treatment includes regular lid cleaning (with boiled cooled water or normal saline, or even a solution of baby shampoo as it cleans effectively but is unlikely to sting if it enters the eye), topical antibiotics such as chloramphenicol ointment (on prescription as OTC chloramphenicol products are not licensed for this indication), and tear supplements for any dryness. When examining a lid margin, be aware that basal cell carcinomas (BCC) may occur there. The absence of eyelashes on an area of the lid may be the only signs of an underlying BCC in the very early stages.

Cataracts (see picture 11)



One of the commonest and most easily treated causes of a deterioration in vision are cataracts. They are more prevalent in the elderly and may be associated with diabetes, use of corticosteroids (particularly steroid eye drops and creams applied around the eye, but any steroid treatment can affect the eyes) and trauma to the eye. Current lens replacement techniques require an incision of less than 2mm in length and can be performed under local anaesthesia. In many areas, patients can be referred directly to secondary care by opticians rather than having to see a GP, but this should only be undertaken where there is a reduction in visual acuity that is bothering the patient. If there is suspicion of diabetes, a fasting blood sugar test should be performed.

Nigel Stollery is a GP in Leicestershire and clinical assistant in dermatology at Leicester Royal Infirmary.

Your Continuing Professional Development CPD

Act

- Re-read the Pharmacy Update article, Is it skin cancer? by the same author (C+D, August 18, 2007, p17-20) and carry out the CPD actions if you have not already done so.
- Read the C+D Guide to OTC Medicines and Diagnostics section on products for dry skin and select those you think would be most suitable for older people (bearing in mind the risk of falling in a slippery bath, the need for more intensive skin hydration and ease of use for those with limited mobility).
- The British Dermatologists' Association website (www.bad.org.uk) has patient leaflets on some of the conditions mentioned in the article. There is also a simple guide – Looking after Elderly Skin – that could be printed off for patients.
- Read more about cataract surgery on the health encyclopedia section of www.nhsdirect.nhs.uk
- Drugs such as steroids, long-term aspirin, gold, phenothiazines and amiodarone have been associated with deposits in the lens/cornea. Have any of your elderly patients taking such drugs experienced a deterioration of vision? Find out when they last had a sight test (which is recommended at least every two years even if they do not wear glasses). List other drugs that might be associated with sight problems, particularly in the elderly.
- Read more about the causes and treatment of chondrodermatitis nodularis helicis chronicus on www.gpnotebook.co.uk/simplepage.cfm?ID=1080754247

Evaluate

- Are you now more aware of the skin and eye problems the elderly might experience? Is there any way you could take a more holistic approach to their wellbeing when advising on medicines?

CPD Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the July 5 issue, which will cover this month's three CPP-accredited modules.

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on **01732 377269**.

Chemist+Druggist in association with Genus Pharmaceuticals

C+D GENUS PHARMACEUTICALS

Practice Certificate in PHARMACY MANAGEMENT

PCiPM

Module 1.4 with this issue

Practice Certificate in Pharmacy Management

Be a better manager

The Practice Certificate in Pharmacy Management is a distance learning course delivered in association with Medway School of Pharmacy. It is designed for anyone who manages, or aspires to manage, a community pharmacy.

Ten training modules are being delivered FREE to C+D subscribers every month from March 2008, supported by an eductional grant from McNeil Products Ltd.

Together these 10 modules make up two Short Courses within the Medway Short Course Pathway. Each course, on completion, is worth five points towards a postgraduate Certificate qualification.

- **Building your team**
- **Leadership and communication**
- **Managing yourself**
- **Corporate governance**
- **Communication in organisations/meetings**
- **SOPs and audit**
- **Managing risks and solving problems**
- **Strategic planning**
- **Project management and change**
- **Marketing your business**

If you have missed any modules you can download them free of charge by visiting www.chemistanddruggist.co.uk/pharmacists. For information on registering for assessment, please complete the slip below and return to Pauline Sanderson, CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent, TN9 1SE. Tel: 01732 377269. Email psanderson@cmpmedica.com

YES, please send me more information on registering for the Practice Certificate in Pharmacy Management

CUT HERE

Name:

Address:

Postcode:

Email:

in association with Medway School of Pharmacy

University of Kent

University of Greenwich

Supported by an educational grant from McNeil Products Ltd.

Clinical Alerts

New Products

Toviaz 4mg and 8mg prolonged-release tablets (fesoterodine fumarate) New product for treating symptoms of overactive bladder syndrome. Pfizer, 01304 616161.

Cialis 2.5mg, 5mg (tadalafil) New strengths for daily dosing. Eli Lilly, 01256 315999, ukmedinfo@lilly.com

Tears Naturale single dose eye drops (dextran, hypromellose) Tears substitute for symptomatic treatment of moderate to severe dry eye, including keratoconjunctivitis sicca. Alcon Laboratories, 01442 341234.

SPC Changes

Xyloproct ointment (hydrocortisone, lidocaine) Changes to composition and form. Also warnings on interactions and use in patients with untreated bacterial, viral, pathogenic fungal or parasitic origin infections. AstraZeneca UK 01582 836836, medical.informationuk@astrazeneca.com

Tegretol Chewtabs 100mg, 200mg; tablets 100mg, 200mg, 400mg; Suppositories 125mg, 250mg; Retard tablets 200mg, 400mg (carbamazepine) Extensive revisions. Novartis Pharmaceuticals UK, 01276 698370, medicalinfo.phgbfr@novartis.com

Malarone Paediatric Tablets (atovaquone, proguanil) Added statements on use in children under 5kg, and psychiatric and cardiac events. GlaxoSmithKline UK, 0800 221441, customercontactuk@gsk.com

http://emc.medicines.org.uk

Study casts doubt on AF treatment

Treatment to control heart rhythm in atrial fibrillation may be no more effective in preventing death than controlling heart rate, a study of 1,376 patients has revealed.

The results cast doubt on the value of the standard treatment approach, which focuses on controlling rhythm.

The study published by the New England Journal of Medicine compared the effects of rhythm and rate control strategies in patients with congestive heart failure and a history of atrial fibrillation.

The subjects were divided into two groups: one was given treatment to maintain sinus rhythm, while the other received treatments to control heart rate. The primary outcome of time to death from cardiovascular causes and a range of secondary outcomes were similar in each group.

The authors wrote that the standard treatment approach of controlling rhythm in AF is based on the observation that AF is a predictor of death.

http://tinyurl.com/4xysgb

Infliximab top for psoriasis

Infliximab is the most effective biological agent used in treating psoriasis, followed by etanercept, efalizumab and alefacept, a meta-analysis published by the British Journal of Dermatology has reported.

However, the same study also revealed a previously unreported modest increased risk of adverse events for alefacet (relative risk 1.09), efalizumab (RR 1.15) and infliximab (RR 1.18).

The results showed no evidence of increased adverse events in subjects treated with alefacept, etanercept or infliximab, but analysis of four of the trials included in the meta-analysis found a possible increased risk of psoriatic flare and infection relating to patients treated with efalizumab.

http://tinyurl.com/4b5voy

Get the measure of children

Campaigners have called for a coherent national strategy to improve the way child growth is monitored.

In launching the Open Book educational initiative on charting child growth, the Infant and Toddler Forum revealed research figures showing that 48 per cent of health visitors and school and community nurses did not feel confident in calculating children's body mass indices, which is the key diagnostic indicator for overweight and obesity.

www.infantandtoddlerforum.org

Revised CVD risk calculator unveiled

An updated version of the QRisk cardiovascular risk calculator has been launched by the developers, primary care systems supplier EMIS and the University of Nottingham.

EMIS clinical director Dr David Stables claimed QRisk2 is likely to be a more efficient and accurate tool for treatment decisions.

The research on which the calculator is based revealed that men of Pakistani background are nearly twice as likely to suffer a heart attack or stroke than the general population, and that for Bangladeshi men the risk rose to 70 per cent more.

A report on the QRisk2 research and calculator is available from the BMJ website.

http://bmj.com

NPC updates guide

Moving Towards Personalising Medicines Management is an update of the original 2002 NPC guide Modernising Medicines Management.

The new guide includes many examples of how services are becoming more personalised.

The guide is downloadable from http://tinyurl.com/4g4bfq

MUR ZONE

Find more than 90 MUR tips and guides online at: www.chemistanddruggist.co.uk/murzone

Health professionals should spot diabetes symptoms

Diabetes UK is calling on health professionals to improve their knowledge after an 8 per cent hike in diabetes diagnoses in under-18s following emergency admission last year.

The charity called for better awareness of the early symptoms of diabetes among health professionals, and for access to high quality specialist diabetes services for children and young people living with diabetes.

Often, it said, diabetes was only diagnosed when diabetic ketoacidosus was identified.

Some 3,317 cases of young patients admitted to accident and emergency departments with diabetic ketoacidosus were recorded last year, said the charity, which also claimed the UK has the lowest number of children achieving good diabetes control in Europe.

"The number of children being rushed to A&E with such a life-threatening complication is shocking," said Diabetes UK chief executive Douglas Smallwood.
http://tinyurl.com/4a9zap

Chinese medicines led to hospitalisation

A 16-year-old male admitted to hospital with recurrent abdominal pain and headache had taken 114 traditional Chinese medicine tablets per day for three to four months, the MHRA has reported.

The tablets were for acne and sleeping problems.

The MHRA said that while there was no clear evidence of what caused the pain symptoms, they could have been partly due to the large quantity of traditional Chinese medicines consumed.

The case also highlighted the potential risk of interactions due to combining different herbal products.

MHRA officials have also reported that a traditional Chinese medicine outlet in London was found supplying out-of-date and illegal medicines.

• The consulting period for an MHRA review of the regulations on the sale of traditional Chinese medicines closes on June 30.
http://tinyurl.com/5ldtmz

To get news of SPC changes and new products emailed to you each week, sign up at: www.chemistanddruggist.co.uk /register

Clinical News

Interruptions OK for AF

A study has shown a low increased incidence of thromboembolism and bleeding among patients with atrial fibrillation whose anticoagulation was temporarily interrupted for an invasive procedure. The study also showed the incidences of TE and bleeding were not affected by the use of bridging therapy.
http://tinyurl.com/3flq74

Nice may back entecavir

The hepatitis B treatment entecavir (Baraclude) has received backing as an option for patients with chronic infection in a Nice final appraisal determination. Final guidance is expected to be published in August.
http://www.nice.org.uk

Locorten back in stock

Amdipharm has announced that Locorten-Vioform 7.5 and 10ml, which were briefly out of stock, are available again. Amdipharm, 01268 823049
medinfo@amdipharm.com

A Practical Approach — Red eye

CONSULTATION

In the Update Pharmacy a young man has asked medicines sales assistant Madeleine for something for conjunctivitis. She has referred him to pharmacist David Spencer.

"So you think you've got conjunctivitis," David says, "Have you had it before?"

"Yes," the man replies, "a couple of times, that's how I know what it is."

"So I can be sure, can you tell me what your symptoms are?"

"Well, first of all, I think you can see that both my eyes are red. They feel a little bit sore, like I've got something in them, but it's not too bad. They are watering a bit as well."

"How long have they been like this?"

"A day or two."

"Any pain?"

"No, just the soreness."

"Is your vision affected?"

"Not really, just a bit blurry, from the watering I expect."

"Did you notice the symptoms in one eye before the other?"

"No, they both seemed to be affected at the same time."

"Well," says David, after some thought, "it seems like conjunctivitis to me and, from your symptoms, probably caused by a virus. Have you had a cold recently, by any chance?"

"No, not a cold, although I did have a cold sore last week. But as you can see, it's cleared up now."

Questions

1. What should David do?
2. Why?
3. In general what three factors can distinguish a minor eye condition that might be self-treated with advice from a pharmacist, from a possibly more serious condition that should be referred?

Answers

1. Refer the man urgently to a doctor or a hospital A&E department.
2. The man may be suffering from herpes simplex keratitis (HSK), caused by the same HSV1 virus that causes cold sores. It can be transferred from the mouth to the eye by touching. The initial symptoms are indistinguishable from a minor viral eye infection but if not promptly diagnosed and treated HSK can cause permanent damage to the cornea and other eye structures, resulting in loss of vision and even blindness. HSK infection occurs in about one or two per 1,000 of the population; the most common age for first occurrence is 30 to 40. Following initial infection, at least half of people will have a further episode within 10 years and one in 10 within a year, so sufferers need to be vigilant and seek treatment as soon as symptoms appear.

Treatment is with aciclovir eye ointment; chronic sufferers (more than one attack per year) may be prescribed oral aciclovir prophylactically.

3. Presence or absence of pain, distribution of redness over the cornea and whether vision is affected. In minor eye conditions there may be irritation and discomfort, but no pain; redness extends over the entire eye surface; vision is unaffected, although there may be slight blurring. In potentially more serious conditions there may be pain; redness may be localised; vision may be affected.

Can you suggest a scenario for Practical Approach? Email ideas to haveyoursay@cmpmedica.com

This article can help in the following CPD competencies: **G1a, G1d, C1a, C1f.**
See http://tinyurl.com/63ox7b

C+D's A Practical Approach is supported by APOTEX UK LTD

from the feeling of dry, irritated eyes

New **blink**® **intensive *tears*** protective eye drops have a unique formulation that holds moisture in the eye for over 60 minutes[1] – providing your customers with long lasting comfort and relief from the feeling of dry, irritated eyes

References: 1. AMO data on file. October 2007.

AMO United Kingdom Ltd, Jupiter House, Mercury Park, Woodburn Green, High Wycombe HP10 0HH

2008.03.03-EC172

AMO®
ED MEDICAL OPTICS

Solpadeine's on red alert

Pharmacists are being invited to paint the town red in the annual point of sale (PoS) drive for Solpadeine.

Picking up from the recent 'explosive' outdoor advertising campaign, the point of sale toolkit will bring an "explosion of colour" to independent pharmacies, says manufacturer GSK.

Among the PoS items in the 'big bang' kit, available from GSK's territory business managers or from the number below, are cubes, standees, wobblers and posters.

Pharmacies participating in the related window display competition, details of which are available from territory business managers, stand a chance of winning a branded chair for the consultation room.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Blink can make your eyes water

New to the eyecare fixture is Blink intensive tears protective eye drops from AMO.

The lubricating eye drop is said to give a lasting solution to dry, irritated or uncomfortable eyes.

According to AMO, the eye drop can hold moisture in the eye for over 60 minutes. In consumer trials, improved vision quality and eye comfort were reported following application of the drops.

Supporting the launch, PR activity is running in national newspapers, consumer magazines and online, highlighting the effects of moisture loss from the eye. Point of sale materials are available.

Prices and Pip codes:
£1.89/5x0.4ml, 339-4780;
£4.99/20x0.4ml, 339-4772;
£4.99/10ml, 339-4798
Advanced Medical Optics
Tel: 0800 376 7950

COPD explained

Understanding COPD – Chronic Obstructive Pulmonary Disease is the latest title to join the Family Doctor series of medical books.

Aiming to give the reader a better understanding of the condition and its management, the book includes chapters on diagnosis, treatment and patient support.

Price: £4.75
Pip code: 339-4343
Family Doctor Publications
Tel: 01202 668330

Canesten AF doubles its appeal

Canesten AF Dual Action is the new name for Canesten AF. The change has resulted from consumer feedback, says manufacturer Bayer Consumer Care, and aims to convey the dual benefits of the product.

The Dual Action name now appears on the cream and spray formats of Canesten AF, conveying its antibacterial and antifungal properties.

According to the Canesten brand manager, the dual action of Canesten AF is a motivating factor for purchase and the 'dual action' words are expected to help communicate the product's benefits to customers.

Product info:
Ceuta Healthcare
Tel: 01202 780558

Retail TALK — Do you link sell tissues and hayfever treatments?

WEB VERDICT:

Yes: 11%
No: 89%

Off the shelf view: There's got to be some potential here. With Kleenex's figure of two-thirds of hayfever sufferers not buying tissues, they clearly need a gentle reminder. Or maybe the medicine's working so well they don't need tissues any more.

This week: What would you squeeze into your suitcase as a last-minute holiday essential? Vote at **www.chemistand druggist.co.uk/prodnews**

Products advertised on TV next week

Benadryl Allergy Relief: All areas
Bepanthen: All areas
Canesten: All areas
Compeed Blister Plasters: STV, U, C, Y, W, LWT, C4, five, GMTV, Sat
Curanail: GMTV, C4, Sat
Feminax Ultra: All areas
First Response Early Results Pregnancy Test: All areas
Frontline Spot On: GMTV, five, Sat, West Country
Lamisil Once: All areas
Lanacane Anti Chafing Gel: All areas
OdorEaters: All areas
PerspireX: Sat
Poligrip: All areas
Sensodyne: All areas
PharmaSite for next week: Solpadeine – windows, **Solpadeine** – in-store, **Solpadeine** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

For more pictures and videos of the Awards, visit **www.chemistanddruggist.co.uk/awards**

Oh, what a night!

The applause, conversation and wine all flowed as Chemist+Druggist celebrated community pharmacy's trail-blazers at its inaugural C+D Awards

C+D editor Gary Paragpuri opens the Awards, saying: "The finalists are blazing a trail for community pharmacy"

C+D marketing manager Emily Miles (left) smiles for the camera with finalist Bobby Mehta and guest

Below: Lucky raffle winner Helen Rowlands, from GSK Consumer Healthcare, received two tickets for a flight to Dubai courtesy of Emirates/Citibond/Sigtravel. Sigma Pharmaceuticals MD Bharat Shah (left) and Citibond Travel general manager Hiten Pindolia presented the prize

Pharmacy Assistant of the Year winner Amanda Wells is presented with her award by OTC editor Fiona Salvage

> "I'm blown away... this award is justification for the direction we've taken and the enormous effort the team have made"
>
> Stephen Foster, Pierremont Pharmacy, winner of Clinical Service of the Year

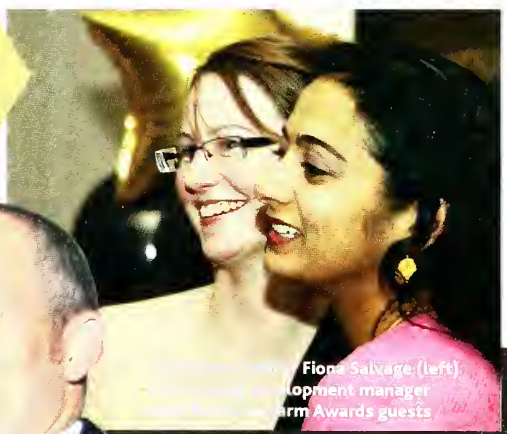
Don't miss out next year! Sign up to C+D newsletters to be alerted when entries for the C+D Awards 2009 open, at **www.chemistanddruggist.co.uk/register**

Comedian Michael McIntyre entertains the audience

Lloydspharmacy pharmacy director Andy Murdock enjoys compere Michael McIntyre's jokes

Above: Every one's a winner. The stars of the evening get ready to celebrate

For more pictures and videos of the Awards, visit **www.chemistanddruggist.co.uk/awards**



Fiona Salvage (left) [illegible] Pharmacy Awards guests

Below left: Bernard Mweseka from Day Lewis Pharmacy, North Woolwich (shortlisted for Pharmacy Manager of the Year) and his sister chat with guests

"I'm over the moon! I can't believe it"

Pharmacy Manager of the Year winner Nichola James

Don't miss out next year! Sign up to C+D newsletters to be alerted when entries for the C+D Awards 2009 open, at **www.chemistanddruggist.co.uk/register**

A "delighted" Pharmacy Team of the Year, from Manchester's Prestwich Pharmacy, celebrate with sponsor McNeil's David Mitchell. Contractor Fin McCaul (second left) said: "We have 35 staff now and couldn't have done it without all of them"

Tailor made: a 10-point guide to specials

Sometimes a special formulation is the only thing that fits the bill for a customer. **Tom Hawkins** tells you what you need to know

Just as most of the population are comfortable buying their clothes off-the-peg from the high street, so most patients are content to have their prescription made up with off-the-shelf drugs. For some individuals, however, their particular requirements – whether dictated by circumstance or choice – can only be met by something bespoke. These special formulations ensure the pharmacist provides the patient with a prescription precisely tailored to their individual need. But, by definition, specials are unlicensed medicines and give rise to certain questions, such as who is ultimately responsible, and how are they reimbursed? This 10-point guide covers the essentials.

1 Why are specials prescribed?

The circumstances in which a special may be prescribed are incredibly diverse. There might be no licensed medicine available or, alternatively, the licensed medicine that is available might be in an unsuitable pharmaceutical form.

Sharon Griffiths, general manager at specials manufacturer The Specials Laboratory, explains: "For example, a patient may not be able to swallow tablets of a particular drug and there may be no licensed liquid form available."

Brian Dougherty, chairman of the Association of Commercial Specials Manufacturers (ACSM), says specials are also prescribed in situations where patients have allergies to ingredients such as lactose or magnesium stearate; where they can provide an exact dose for patients being titrated antibiotics; and for neonates, where small doses are required.

Mr Dougherty says specials are also used to reproduce dermatological product formulations that date back to the 1930s. Psychiatric patients might even require a change to their medicine simply because of its colour, he adds.

2 How are specials prescribed?

Details of a special formulation are hand written by a prescriber and then compounded or procured by the pharmacist prior to dispensing. However, this simplified description of the process belies the potential for mistakes.

Vyan Fenwick, senior production pharmacist at manufacturer BCM Specials, advises that simple checks be carried out to ensure both prescriber and pharmacist are clear on the type of formulation being dispensed.

"The GP should be contacted to confirm the prescription and to inform them that they have prescribed a special and the possible consequences of using such an unlicensed product," she says.

Moorfields Pharmaceuticals is a specialist in ophthalmic specials and managing director Alan Krol also advocates communication with the prescriber. "The pharmacist may well discuss with the prescribing clinician to confirm dosage, or in some instances, a light change to the prescription based on advice from the specials supplier about formulation and availability," he says.

3 How are they sourced?

With pharmacists' energies increasingly focused on MURs and clinical services, specials are typically bought direct from manufacturers, which must hold a Manufacturers 'Specials' Licence from the MHRA. This requires the premises to be audited to ensure it meets the quality standards that also apply to licensed product manufacture.

Wholesalers can hold stock of specials but because they have a short shelf-life they are usually purchased to order. Mr Krol adds: "If the special is particularly unusual and there is little data available about it then it will be given a very short shelf life."

Mr Dougherty says because of their short shelf life, it is important for pharmacists to acknowledge quickly that a special might need to be stored in the refrigerator and to pass that information on to the patient.

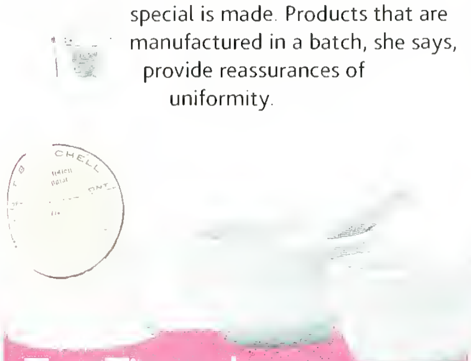
4 What details should be discussed when ordering?

With forms ranging from capsules to lollipops and everything in between, as well as a variety of flavours on offer, it is important for the pharmacist to clarify the precise product requirements with the manufacturer.

Ms Griffiths says specials manufacturers can often provide their own formula for certain prescriptions and refine details such as flavours prior to dispensing.

She says: "Pharmacists should ask about the shelf life and storage conditions of products, and if ordering a liquid for a child, then they should enquire about the available flavours."

Jan Flynn, marketing manager of Rosemont Pharmaceuticals, advises pharmacists to ask how the special is made. Products that are manufactured in a batch, she says, provide reassurances of uniformity.



Top Tips when selecting a supplier

- Does the company hold a Manufacturers 'Specials' Licence?
- What is the turnaround time from order to delivery?
- Does the company offer a 24-hour service if needed?
- Does the company specialise in any particular type of product?
- Does the company provide certificates of analysis?
- Does the company guarantee quality?
- Is professional advice available?

5 Who is responsible for a special?

The prescriber is responsible for the dose and clinical effect, including any side effects, of a special, says Mr Dougherty of the ACSM. The pharmacist in turn has a responsibility for procuring or compounding the product that meets the specification provided.

Part of the pharmacist's process is simply checking that the prescription has therapeutic value and that it is definitely off-licence. And, pharmacists might need to confirm details such as the base of the cream or ointment.

Ms Fenwick says: "The dispensing pharmacist must take responsibility for dispensing the medicine. If the pharmacist has any concerns with the non-licensed item which has been prescribed, they should contact the prescriber." She adds: "Everyone in the supply chain needs to be aware that the item is not licensed. The pharmacist has an important role to play in informing all concerned."

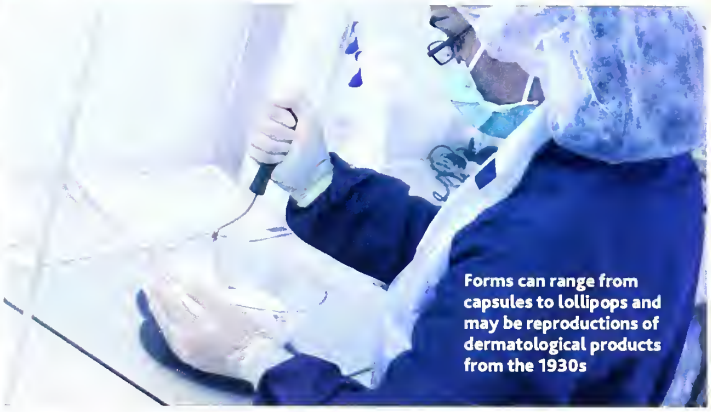
Mr Krol predicts there will be more regulation around specials in the future because of the increase in global trade. This has resulted, he says, in a rise in a different kind of special: those products that are licensed in their country of origin but are unlicensed in the UK. Currently the MHRA must give permission for the use of these products.

6 Are there risks involved in the supply of specials?

Mr Dougherty of the ACSM explains that there is an unavoidable element of risk in prescribing a special because of the fact that it is unlicensed. The prescriber and pharmacist must consider this when a licensed option is not appropriate, he says.

"By their very nature, specials have no information on bioavailability, and doctors and pharmacists are quite often working in the dark as far as the dosing is concerned."

Ms Flynn adds that even with safeguards around manufacturing quality, the pharmacokinetics and pharmacodynamics of the same special can vary when produced by



Forms can range from capsules to lollipops and may be reproductions of dermatological products from the 1930s

different manufacturers: "Continuity of care is vitally important so discussion with the surgery is extremely important," she says.

7 How much do specials cost?

As a bespoke product, produced in small quantities at short notice, specials cannot be manufactured with economies of scale and are charged at a premium.

Their status as a premium product means specials can temporarily eat into cashflow. Some manufacturers are able to mitigate this through advances in shelf life.

"Once we have sufficient shelf life on a product then we are able to make the product in batches as a stock line," explains Ms Fenwick. "We are then able to significantly reduce the cost of manufacturing the item. This saving is then passed onto the pharmacist. For example, we have recently reduced the cost of a particular 100ml liquid preparation by 80 per cent by making it a stock line."

8 How are they reimbursed?

Specials are reimbursed in full by the Department of Health, along with any delivery charges, which can be claimed as out-of-pocket expenses. This is as long as they are not available as a licensed product in the Drug Tariff.

Ms Griffiths says: "The pharmacist must ensure that the product they are asking for is not included in the Drug Tariff as they would only be reimbursed the Drug Tariff price."

Where a licensed product is unavailable, the prescriber should be consulted so that a licensed alternative can be suggested. If it is deemed that a special is ultimately required then the prescription should state the name of the manufacturer and it will be reimbursed appropriately.

9 What are the trends in the specials market?

Mr Krol says any increase in the use of specials is linked to clinicians' ability to better identify individual patient needs. And these needs are changing, he says, based on environmental and demographic factors.

For example, an ageing population means occurrences of eye conditions such as wet age-related macular degeneration are on the rise, and more air conditioned offices and an increased use of computers have led to more cases of dry eyes. He also points to trends such as the growth of allergies in younger people.

Ms Flynn says dysphagia among the ageing population makes liquid formulations preferable to solid medication that can be difficult to swallow.

10 Who can I call for help with a special?

The label on a special will provide details on storage and shelf life but manufacturers cannot provide information on dosage. "Due to the bespoke nature of the products, there is no data sheet or patient information leaflet for us to distribute," says Ms Fenwick.

Suppliers should, though, be able to provide information about manufacturing processes or the individual product on request. This could include certificates of conformance or analysis, and quality information on levels of sugar or preservative content, for example.

C+D

0207 921 8333

Booking and copy date
12 noon Monday prior
to Saturday publication subject
to availability

Contact:
Simon Pittman
Chemist+Druggist (Classified),
CMP Medica Ltd
Ludgate House
245 Blackfriars Road
London SE1 9UY

T: 0207 921 8333
F: 0207 921 8130

www.chemistanddruggist.co.uk
c&dsales@cmpi.biz

Dispensers / Technicians

HEALTH CENTRE PHARMACY

We are looking for an enthusiastic full time dispenser/dispensing assistant to join our team in this busy, friendly health centre pharmacy. Training will be provided if needed. The ideal candidate will be working closely with the complete health care team in order to deliver NHS service.

Please apply with a C.V. to Beran Patel at 020 8689 7127 (beranpatel@hotmail.co.uk)

Brigstock Pharmacy
141 Bridgestock Road
Thornton Heath
Surrey CR7 7JN

Dorking, Surrey

Dispenser/Technician required for busy, friendly community pharmacy, preferably qualified or experienced.

Please contact Maria Chadwick on 01306 882 728.

Business For Sale

HUTCHINGS PHARMACY SALES

Cambridge	**T/O C:**	**£1,750,000**
S. West	**T/O C:**	**£1,100,000**
Cambridge	**T/O C:**	**£900,000**
Exeter	**T/O C:**	**£800,000**
Herts	**T/O C:**	**£770,000**
Coventry	**T/O C:**	**£690,000**
N. London	**T/O C:**	**£500,000**

If you are ready to SELL we have purchasers throughout the UK willing to pay top prices for Pharmacies. Our priority is to obtain the best price whilst maintaining your confidentiality.

If you are thinking of SELLING your Pharmacy, Contact us now for a FREE valuation.

Or for a confidential discussion please call...

01494 722224

email: info@hutchingsandco.com

www.hutchings-pharmacy-sales.com

Hutchings Consultants Ltd

"We are the only NPA approved supplier for selling your pharmacy"

National Pharmacy Association Approved Supplier

Business For Sale

Business sales and development

Sales

Sellers!

Despite the impact of category M, we have a large register of buyers actively looking to acquire!
..and our fees are Market-leading, with no long-term tie-in.
Call us for a no obligation appraisal

Development

Business Health-Check

If you want to have an edge over your competitors then ask us about our "Business Health-Check"

David Parker Consulting Ltd
www.davidparkerconsulting.co.uk
Mob: 0789 423 4873
david@davidparkerconsulting.co.uk

Chemist+Druggist is rated the best source of information for pharmacists*

To place an advert in the classified section please contact Simon Pittman on 0207 921 8333 or email: spittman@cmpmedica.com

***May–June '07 Linda Jones Associates**

Business Wanted

MANOR PHARMACY

Pharmacy Group looking to expand and acquire shops in the North-West & North/West Yorkshire areas.
All turnovers/ size of group considered.
High Premium Paid. All information will be treated with the strictest confidence.
Please contact Mohamed on 07958 428754 or Talha Patel on 07841 328394

Products and Services

Is it time you reviewed your loan guarantee arrangements?

Tel: 01928 750648

PHOENIX Think

CAMRx
Pharmacy Development Group

DO NOT MISS THIS OPPORTUNITY TO PROFIT BY £1,000
(offer ends 31 July 2008)

♦ **New members** joining CAMRx in June/July will qualify for **£1,000 free generic stock** at DTF value

Plus
Achievable benefit of **Zero Threshold**

And
Obtain up to **11.5% discount** on your **eligible medical purchase**

♦

Have benefit of **fully subsidised** computer hardware, monthly software, installation and training package **worth £4,400**

♦

Gain benefit **of share of profits** without having to invest **your own money** in a **share purchase scheme**

For further details contact CAMRx Customer Services on 01530 510520 quoting reference **CDJUNE**

Products and Services

First Aid Warehouse

www.firstaidwarehouse.co.uk
17 Chesford Grange, Woolston, Warrington, WA1 4RQ

Does your business need a more flexible approach?

We can offer complete or tailored business services - allowing you to focus on sales

We can provide

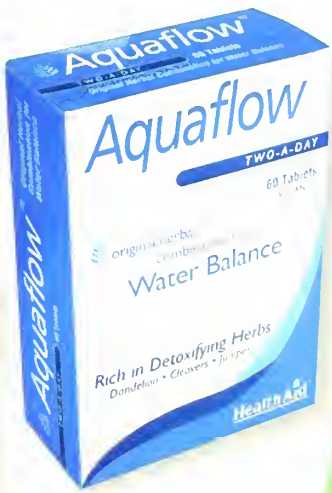
- Professional customer services team – over 40 years experience in medical & pharmaceutical products
- Full order processing, customer query and advice service
- Integrated online ordering & secure payment processing - web design and ecommerce services
- Marketing campaign response management
- Managed warehousing & distribution services – next to M6/M62
- Quality & Regulatory Affairs licences for handling and distribution of General Sales List (GSL), Pharmacy (P), & Prescription Only Medicines (POM)
- National Sales Team

For an informal discussion about how we may be able to help call Paul Cartwright on 01925 898263

Goodness from Within...

Hair-vit

- Essential B vitamins, trace elements, minerals and amino acids
- Optimum nourishment from within
- Suitable for men and women



Aquaflow®

- Contains 10 carefully selected plants and herbal extracts that have natural detoxifying and antiseptic properties
- Help to maintain water balance and a healthy urinary tract.
- Lighten Up, Feel Great

For further information on our wide range of high quality food supplements contact us.

HEALTHAID LTD
HealthAid House, Marlborough Hill, Harrow, Middlesex, HA1 1UD, UK
Tel: +44(0) 20 8426 3400 Fax +44(0) 20 8426 3434
Email: sales@HealthAid.co.uk

HealthAid®

www.HealthAid.co.uk

Shop Fitting

Tax Consultants & Accountants

Tax Consultants & Accountants

postScript

**What have you and your team been up to lately?
Let us know and send us your photos.
Email postscript@cmpmedica.com**

LMC conference: the alternative

The recent conference of representatives of local medical committees (LMCs) was a lively event, but PostScript was disappointed to note that certain motions were not selected for debate. Particular favourites were: "Conference recommends Laurence Buckman should carry out a radical overhaul of surgical services, and then receive a peerage," Avon LMC. "Conference believes Jilted John showed remarkable foresight with his 1980s song line 'Gordon is a moron'," North Yorkshire LMC and supported by Bradford and Airedale. "That while this conference recognises the success of the English rugby team against Australia in the recent World Cup, it notes miracles do occur and the divine intervention is a deep and mysterious thing rarely understood by men," Bro Taf LMC.

Web comment of the week

Category M 'relatively stable' this quarter Posted by K Dhanoa, on 13/06/2008 09:07

"The **Cat M clawback** was meant to be **over four quarters** ... surely October's Cat M should be the **end of all this madness** and not, as Mr Shah indicates, the **quiet before the storm** because if it is, it'll be the **government owing us money**"

Have your say on C+D's website
register for free at www.chemistanddruggist.co.uk

Let there be light...

A meeting on pharmacy education held at the Cabinet War Rooms in London last week took an unexpected turn when a power cut plunged the venue into darkness.

But sponsor McNeil and the Cabinet War Rooms staff took it all in their stride. Candles were placed on the tables, and diners were given their first course of miraculously hot soup.

The candlelit ambience continued into the main course – no questions were asked about how the fish and meat were cooked! – until suddenly the lights flickered back to life.

Once the cheering had subsided, there was much debate about whether dining in the dark had much to recommend it. The general consensus? That the experience had only added to the authenticity of an event held in a venue commemorating how Blighty won the war.

Dragon slayer

A young pharmacist has beaten a Dragons' Den contestant and a vehicle salvage expert with over 35 years' experience in his field to be named Entrepreneur of the Year, in South Hertfordshire and North and North West London's Business Excellence Awards (BEA).

Carter Chemist's Hatul Shah, who was short-listed for New Pharmacist of the Year at last week's C+D Awards, was praised by the BEA for his vision, passion and drive. The BEA judges said: "Hatul Shah's charisma has helped to generate a feeling of confidence in his team that motivates his people to e..." Hatul is pictured with his wife, Sonia.

Rowlands' star students

Glasgow pre-registration graduate Kirstie Cameron (pictured, centre) has been named Rowlands Pre-Reg of the Year.

Rowlands' education, training and recruitment manager Sandra Hutchinson (left) praised Kirstie for her "proactive approach" and "incredible commitment". Presenting the award with Rowlands superintendent Ian Cowan (right), Ms Hutchinson said: "She will be a great pharmacist as she motivates and encourages others to develop so well."

Joanne Philbin (second right) took the Best Professional Development Award, and Sarah Oak (second left) walked away with the Best Personal Development Award.

Pride of Britain

Former pharmacist Douglas Cook cuts the ribbon on The Co-operative Pharmacy's new-look branch in Hartlepool, following a £180,000 refit. Douglas worked at the York Road pharmacy for nearly 50 years before retiring in 1997. Co-operative staff presented him with a £200 cheque for his chosen charity, Great Ormond Street Hospital.

The Co-operative Pharmacy will be celebrating the achievements of remarkable Britons as part of The Co-operative Group's sponsorship of the Pride of Britain Awards.

Pharmacy managing director John Nuttall (inset, with Pride of Britain Awards trophy) said: "As a business that is dedicated to supporting the communities in which we work, as well as the individuals who work within them, I can't think of a more appropriate awards scheme for us to support."

COUNTERPART+
PHARMACY ASSISTANT DEVELOPMENT

Want to be sure your staff are learning what they're reading?

Haven't the time to train them yourself?

Enrol them onto Counterpart Plus for just £25 for 12 months and let us do the work for you.

If your staff are reading the Counterpart Plus modules in OTC, why not test their knowledge each month on the Counterpart Plus course and reward them with a certificate outlining their achievement.

Yes! Please enrol my staff on the Counterpart Plus course

Pharmacist/manager.....Pharmacy.....

Address.....

.....

.....Postcode.....Telephone.....

Orders will not be accepted without a telephone number

Email.....

Course registration fee of £25 per person (inc VAT)

Name..... £

Name..... £

TOTAL £

Card Type..... Card number.....

Expiry Date..... Issue no. (debit card) .....

Name (as on card)..... Signature.....

Please send your cheque (payable to CMP Information) or credit/debit card details to:
Pharmacy Projects, CMP Medica Ltd Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE or fax: 01732 377538

- More effective than one a day antihistamine tablets[1-8]
- Protects against allergies caused by pollen, pet hair, house dust mites and mould spores

The most effective once daily airborne allergy relief[1-8]

fluticasone

Flixonase Allergy Nasal Spray Product Information. Presentation: Aqueous nasal spray suspension containing 50 micrograms of fluticasone propionate per spray. **Uses:** Prevention and treatment of allergic rhinitis. **Dosage and administration:** Intranasal use only. *Adults and the healthy elderly:* Two sprays into each nostril once a day, preferably in the morning. Use twice daily if required. Do not use more than 4 sprays a day in each nostril. Prophylaxis of allergic rhinitis requires treatment before contact with allergen. *Children under 18 years:* Not to be used. **Contraindications:** Known hypersensitivity to ingredients. **Precautions:** If symptoms have not improved after 7 days or, if symptoms have improved but are not adequately controlled, consult a doctor. Not to be used for more than 3 months continuously without consulting a doctor. Consult a doctor before use in: concomitant use of other corticosteroid products, nasal/sinus infection, recent nasal injury/surgery, nasal ulceration. Risk of adrenal suppression with higher than recommended doses. Significant interactions between fluticasone propionate and potent inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and protease inhibitors, such as ritonavir, may occur. This may result in increased systemic exposure to fluticasone propionate. **Side effects:** Dryness and irritation of the nose and throat, unpleasant taste and smell, headache and epistaxis. Hypersensitivity reactions including skin rash and oedema of the face or tongue. Rarely anaphylaxis/anaphylactic reactions and bronchospasm. Very rarely glaucoma, raised intraocular pressure and cataract. Extremely rarely nasal ulceration and nasal septal perforation usually following previous nasal surgery. **Pregnancy and lactation:** Do not use except with medical advice. **Legal category:** P. **Product licence number:** PL 00079/0616. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 60 spray pack £6.99. **Date of preparation:** November 2007. **Flixonase** is a registered trade mark of the GlaxoSmithKline group of companies. **References: 1**. Vervloet D, Charpin D, Desfougeres J-L. *Clin Drug Invest* 1997;**13**(6):291-298 **2**. Gehanno P, Desfougeres J-L. *Allergy* 1997;**52**:445-450 **3**. Kaszuba SM *et al. Arch Intern Med* 2001;**161**:2581-2587 **4**. Ratner PH *et al. J Fam Pract* 1998;**47**:118-125 **5**. Jordana G *et al. J Allergy Clin Immunol* 1996;**97**:588-595 **6**. Stricker WE *et al. Ann Allergy Asthma Immunol* 1998;**80**:115 **7**. Bernstein DI *et al. Clin Exp Allergy* 2004;**34**:952-957 **8**. Van Bavel JH *et al. Ann Allergy Asthma Immunol* 1997;**78**:128